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JOINT LEGISLATIVE COMMITTEE ON AGING

Columbia, October 1, 1986

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BY

JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

Columbia, SC - October 1, 1986

Representative Patrick B. Harris, Chairman

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The Annual Public Hearing of the Joint Legislative Study Committee on Aging was held in the Blatt House Office Building, Room 101, in Columbia, South Carolina, on Wednesday, October 1, 1986. The Hearing convened at 10:30 am.

Representative Patrick B. Harris, Chairman of the Committee, called the hearing to order. At this time he welcomed everyone to the 20th Public Hearing of the Committee in his 17 years of service on the Committee. In his opening remarks, Chairman Harris recapped several pieces of legislation that passed which the Committee had worked on for many years such as the Death with Dignity Act and the Probate Code Reform.

Following this statement the members of the Committee and staff were introduced: Secretary, Dr. Julian Parrish, Columbia; Rep. Dill Blackwell, Travelers Rest; Mrs. Gloria Sholin, Hilton Head; Dr. Carlisle Holler, Rock Hill; and Sen. Peden McLeod, Walterboro. Also in attendance but joining at a later time was Vice-Chairman, Rep. Dave Waldrop, Newberry; Sen. Bill Doar, Georgetown; and Sen. Isadore Lourie, Columbia.

Chairman Harris also introduced the Committee staff members: Ms. Keller Barron, Director of Research, Miss Sherri Craft, Administrative Assistant and Mrs. Debra Blakely, USC Master's in Social Work Intern.

At this time Chairman Harris requested that the written remarks from Tom Brown, Director Office of Program Management for the Department of Health and Environmental Control be entered into the record. (Appendix A).

With these preliminary remarks, Chairman Harris called the first speaker.

Rev. M. L. Meadors, Jr.
S.C. Commission on Aging
915 Main St.
Columbia, SC 29202

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Mr. Chairman, distinguished members of the Committee, I am very grateful for this opportunity to have the pleasure and privilege of presenting to the Committee for the first time our new Executive Director for the Commission on Aging.

The Commission was very fortunate to have Ruth Seigler to accept the responsibility of being the new Executive Director. Ruth is experienced in working in state government. She understands the budgeting and legislative process. She has a very high energy level. She hit the ground running and has been busy ever since she came to work with the Commission, meeting with persons throughout the network. She has effective and efficient managerial skills. She is a team player. She works well with the Commission, the staff and I'm sure with your Committee. I simply want to thank you for the privilege of presenting her at this time. For the remainder of the Commission's report we will let Ruth be our spokesperson.

Ruth Seigler, Executive Director
S.C. Commission on Aging -3-
915 Main St.
Columbia, SC 29202

PRESENTATION OF THE S.C. COMMISSION ON AGING
OUTSTANDING OLDER SOUTH CAROLINIAN AWARD-1986

Good morning. Thank you. It's a real pleasure to have this opportunity. It's a day of firsts for me.

The first item that I would like to do, and I'll stand to the side because this is an important activity for the audience as well as the distinguished Committee, to recognize the Outstanding Older South Carolinian for 1986. It is a person that happens to be a friend and a colleague of mine that I hold in very high esteem. This award was initiated by the Commission on Aging in 1971 to recognize an individual 65 and older who has for an extended period of years rendered distinguished service to the community, the region and the state.

This person should provide service as a broad scope and its impact be beneficial to many. This person's individual character must merit the recognition. This year's recipient was nominated by the Council on Aging of the Midlands and the Central Midlands Regional Planning Council. And he is certainly imminently qualified. He has an earned Doctorate from Boston University, was the head of the Department of Biological Services at Boston University, and was the first occupant of the Shields-Warren Professor of Biology Chair. He had a distinguished career in state government as the Director of Health Affairs for the S.C. Commission on Higher Education. He has served as the president and advisor for the Federation of Older Americans and has revitalized its publication The Senior Circle. One of his many current projects is the establishment of the Shepherd Center for the Columbia area.

Please join me in recognizing Dr. George P. Fulton, the Outstanding Older South Carolinian for 1986.

We have two awards to present to George. First the Outstanding Older South Carolinian Award for 1986. And the we have from Bethany College and the "With Wings As Eagles" Institute, the Eagles medallion for promoting the aging society and encouraging a positive attitude toward years of wisdom and integrity.

Dr. George P. Fulton: Thank you all very much. I would like to thank all the individuals and organizations that are responsible for my being here and receiving this wonderful honor.

I think it's a very distinctive honor to have this happen before the Joint Study Committee of the Legislature. It gives cognizance and recognition to all of us older Americans and this important sector that is growing and needs nurturing. And I would like to commend this Committee for holding hearings such as this and Mr. Harris and all members of the Committee. I think I speak for all of us who are here in this. With respect to my award, I could not have done any of the things I may have done here in S.C. if it had not been for all the wonderful friends and colleagues that I have and so they are the ones who really deserve this award.

Thank you very much.

Chairman Harris commended Dr. Fulton on this award. "This award is well deserved and may be long overdue, but we do congratulate you and we're proud of you and look forward to working with you for a long time to come."

S.C. COMMISSION ON AGING PRESENTATION
Ruth Seigler, Exec. Dir.

As I said earlier, It is a real exciting opportunity for me to have this day of firsts -- to give this award and also to have the opportunity to talk with each of you.

It was also a thrill to see the extensiveness of the agenda today. To see the interest of so many groups from across the state to come to Columbia and to share with all of us the interest and the concerns for aging.

You have before you some materials. These are materials that we have developed to provide the budget presentation which will ultimately be a legislative decision. We would like to share with you some of the concerns that we've outlined in the budget because the top two priorities have great implications for the aging network throughout South Carolina.

I would like to call your attention at the break time to the population chart so that you can see the tremendous growth S.C. is experiencing in those 65 and older and especially in the citizens 75, 85 and older.

There will be more than 28 million older Americans by the year 2020. The baby boomers will be senior citizens by that time. So we are planning now for the future of those years. It is urgent that we respond to the fact that the elderly population in S.C. is rapidly increasing and that state government must address the needs of this population. At present we have 345,000 citizens who are 65 and older. This age group will be 11.2% of our population by the year 2000. 45,000 of those individuals are 75 years and older right now. If we compare these past generations of older South

Carolínians, we find that as a group, they are healthier, more educated, financially better off, and politically more active. We can divide the age 65 group into the young-old and the old-old but we must be mindful that great diversity exists within these populations. We have retirees in their condominiums on the Grand Strand. We have native South Carolínians who are pillars of the community even as they celebrate their 80th, 90th, and 100th birthdays if you watch some of the television coverage of these outstanding citizens.

But we also have isolated rural elderly who live alone who have grandchildren and children in far away, distant metropolitan areas. And then we have the nursing home patients whom we call the invisible elderly. As these images come to your mind, we must think about the needs of particularly the frail elderly or the old-old (85 and older). Many of these are women who live alone and cope with three or more chronic health problems. If you look at the poverty rate for those who are over 65, some 25% of the elderly population live in poverty. S.C. is one of the top 9 in the nation for poverty among the elderly. Many of them have prepared for their retirement, however, regardless of their preparation, one of the most serious financial threats that they face is institutionalization when they are no longer able to care for themselves.

One of the proposals that we would like you to give special consideration to is an Alternative Care Program for the Elderly. We are talking about in-home services for the elderly who may not need immediate or imminent institutionalization but who may need in-home services prolong quality of life and quantity of life in their community settings.

We are currently asking for 2.5 million budget funding this year. With the community-based services you will see in the handout that we are talking about some 52,000 citizens who need some type of long term care. Approximately 17,000 of those are currently in some type of institution (the Tucker Center, Crafts-Farrow) and nursing homes in the state. However you are aware of the fact that with some new federal incentives, some of the nursing homes are being required to release some of the patients who are currently there. We are estimating some 800 patients will be discharged from nursing homes this year. So we must look at alternatives for caring for these individuals as well. Certainly the community long term care program has been significant in meeting the needs of many of those people -- some 5000 of them. But not all people in need of this service are eligible either because they are not income eligible to meet the Medicaid criteria or because they don't have enough health care problems to fit them into the category of needing intermediate or long term care. So we are talking about a program that would provide an enhancement of those chronically frail elderly in their home communities and we're proposing that this program occur through the Councils on Aging.

The other priority that we have is to improve our system of understanding what is occurring in S.C. for the elderly and we are proposing a systematized computerized data collection system. So we are asking for budget consideration for this request as well (\$233,000).

SOUTH CAROLINA COMMISSION ON AGING

The legislative mandate of the Commission is to: "study, investigate, plan and execute a program to meet the present and future needs of aging citizens of the state and to encourage and assist in the development of programs for the aging in counties and municipalities." It is urgent that the Commission respond to the fact that the elderly population in South Carolina is rapidly increasing and urgent for State Government to develop the programs to address the needs of that population. The Commission on Aging is committed to long range planning to provide a statewide strategy to meet the needs identified. This is major and we have begun to clearly focus and concentrate our efforts toward this initiative.

In South Carolina, we have approximately 345,900 citizens who are 65 or older. This approximates 10% of our total population. Of the state's population, 45,785, or 1.1% are 85 and older. (See Chart A - S.C. Population Chart). In comparing these with past generations of older South Carolinians, we have made tremendous strides in that they are, as a group, more active, better educated, healthier, financially better off, and more politically active. Even with these advances, the actual number of elderly living in poverty and in need of supportive services continues to grow.

Estimates of the proportion of people age 65 and over needing some kind of long term care range from about 11% to about 20%. Estimates for the proportion of people 85 and over needing some kind of long term care services range from about 35% to 62%.

What is currently being done and what can be done to address this problem? If we use a moderate estimate of 15% of the population over 65 needing some kind of long term care, that translates into some 52,000 people. (See Chart C). About 17,000 of those are institutionalized in some type of licensed long term care facility. That leaves about 35,000 people needing long term care services in the community. (See Chart D).

The S.C. General Assembly has funded a number of important programs that have had a positive impact on the older citizens in S.C. Some of those include Community Long Term Care Program, a tax credit up to \$300 for families whose family member is institutionalized with Alzheimer's Disease or related disease, funds to the Commission on Aging to offer in-home community care for the frail elderly, the Medically Indigent Assistance Act, and the State Appropriations to match and to supplement the Federal Aging Funds for the Older Americans Act. Other significant legislation includes the Homestead Exemption Act, passage of the Uniform Probate Code, and the Living Will Legislation. These programs are making a difference but there is much to be done.

All of the state agencies involved in meeting the needs of the elderly must make concerted efforts to coordinate and collaborate in order to best use the limited resources that are available.

The State of S.C. has made a commitment to offer cost effective community alternatives to institutionalization. We must immediately address programs that offer,

1. Adult Day Care
2. Respite Care
3. Homemaker/Personal Care Services
4. Home Delivered Meals
5. Essential Transportation
6. Adequate Housing Alternatives

CHART A⁻⁷⁻

SCOUTH CAROLINA POPULATION 65 & OVER
1950 to 2010

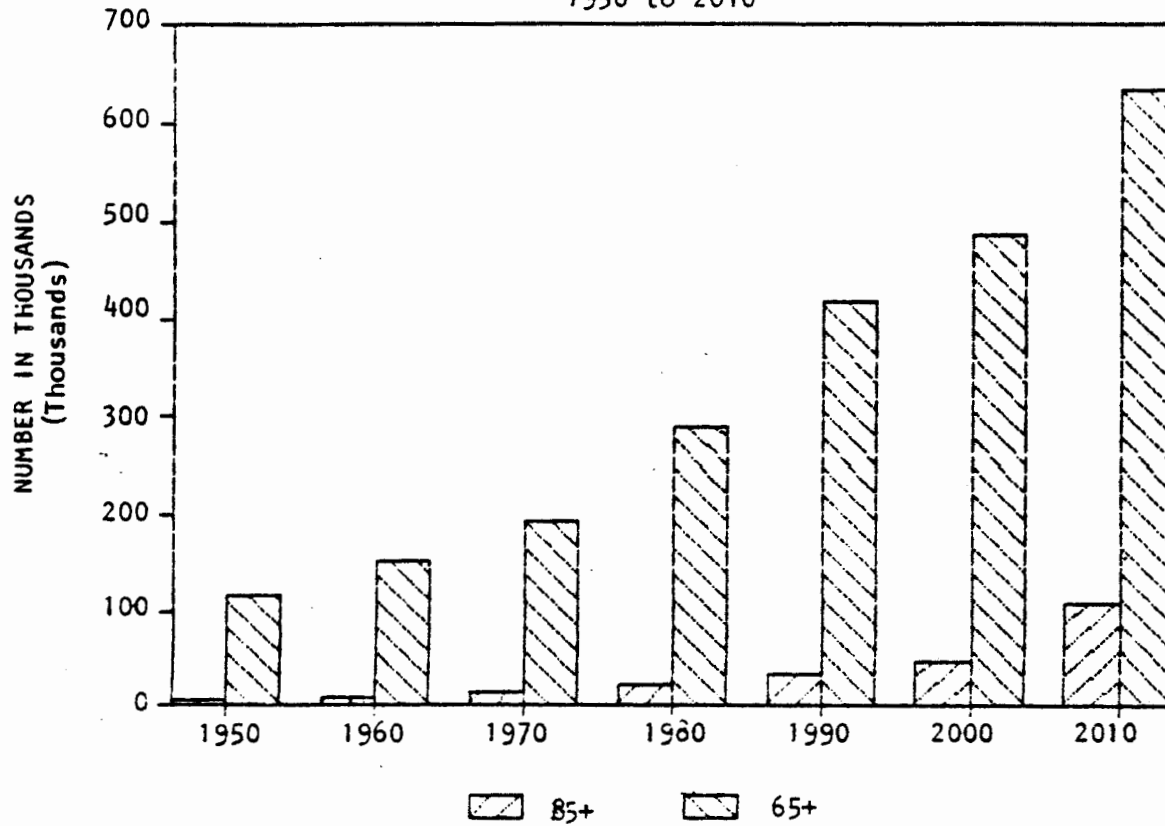


CHART B

UNITED STATES POPULATION 65 & OVER

1940 to 2020

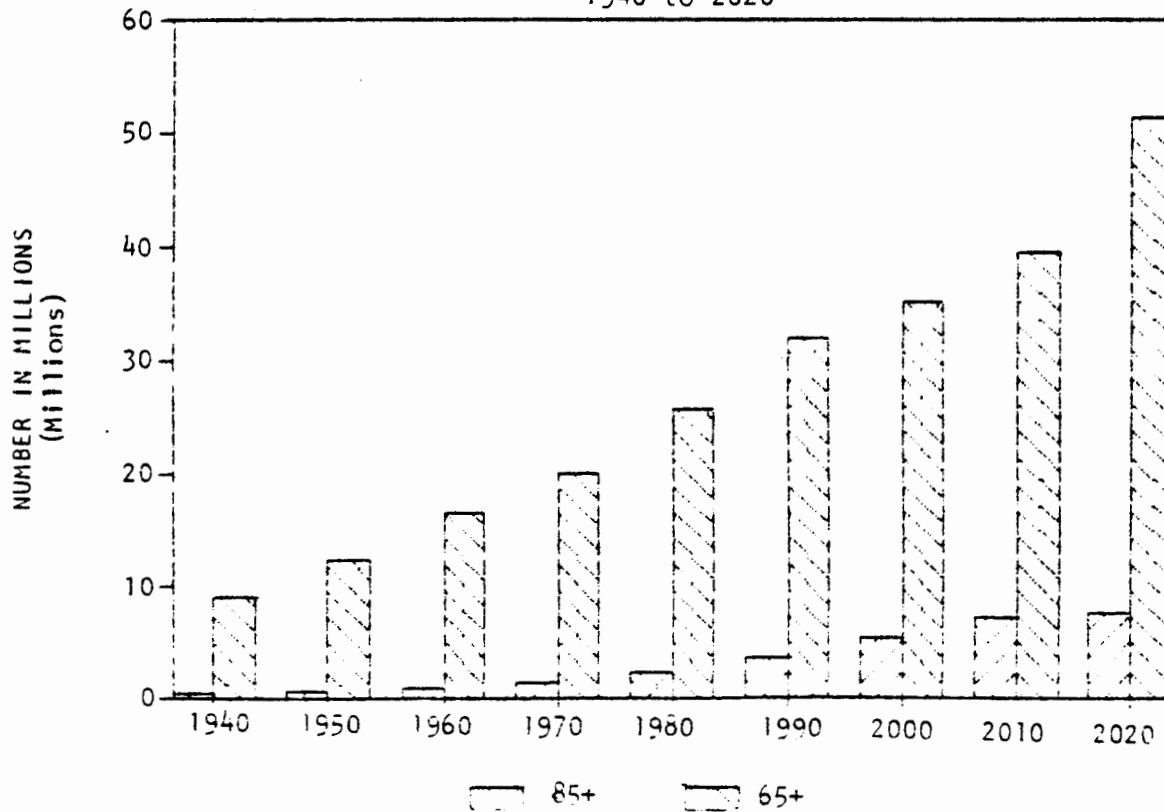
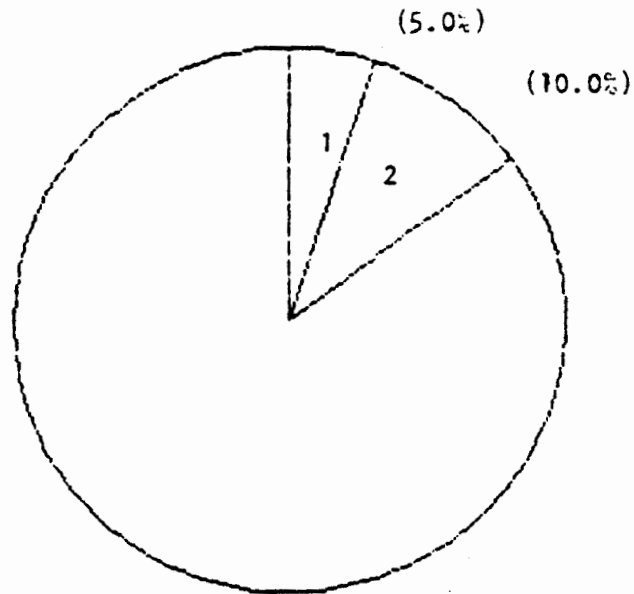


CHART C

PROPORTION OF SOUTH CAROLINA'S
POPULATION 65+ NEEDING LONG TERM CARE*
(N = 345,900)



1. In need of Institutional Care = 17,295 (5% of total)
2. In need of Alternative Community Care = 34,590 (10% of total)

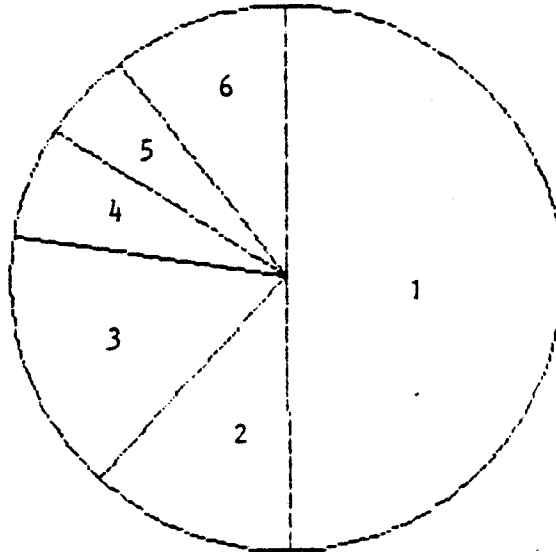
*Based on National Estimates

CHART D

POPULATION 65+ NEEDING AND RECEIVING COMMUNITY-BASED LONG TERM CARE IN SOUTH CAROLINA*

(N = 34,590)

1. Receiving DHEC Home Health
2. Receiving DSS
Homemaker
3. Receiving CLTC
4. Receiving SCCOA
Home-delivered Meals
5. Receiving SCCOA
Homemaker
6. Not Receiving Services



1. 17,255 (49.9% of total)
2. 4,179 (12.1% of total)
3. 5,400 (15.6% of total)
4. 2,291 (6.6% of total)
5. 1,875 (5.4% of total)
6. 3,590 (10.4% of total)

*Some individuals are receiving services from more than one source, so individuals receiving no services exceeds the number shown.

JOINT LEGISLATIVE STUDY COMMITTEE ON AGING
CHAired BY PATRICK HARRIS

Dolores V. Macey, Chief of
Social Work Service
Wm. S. Hall Psychiatric
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P.O. Box 202
Columbia, SC 29202

Mr. Chairman, Members of the Committee and Concerned Citizens of South Carolina,

My name is Dolores Macey and I speak to you in my capacity as Chairperson of the State Advisory Committee on Alzheimer's Disease and Related Disorders, formed in June 1985. We were given the task by the South Carolina Commission on Aging, to study the problems of Alzheimer's Disease as they relate to citizens of South Carolina and make recommendations focusing on problem resolution.

Functions of the Advisory Committee include:

1. Be an advocate for Alzheimer's Disease and Related Disorders for both the patients and their families, and keep abreast of issues affecting these persons.
2. Recommend legislation needed in South Carolina to benefit patients and families.
3. Assist in planning, implementing, and evaluating education and training activities for all target groups affected.
4. Assist in establishing and maintaining Alzheimer's Disease and Related Disorders Support Groups throughout the state.
5. Assist in establishing and maintaining a Respite Care Program.
6. Establish two-way communications with related groups, organizations, and people concerned with Alzheimer's Disease and Related Disorders.

The committee represents a cross-section of the state from health and human services as well as family members of Alzheimer's Disease patients. I have included a listing of the current membership as an appendix to this report.

Why was the formation of this committee necessary? Alzheimer's Disease has been identified as the disease of the century. It affects 2.5-3 million people in the United States and an estimated 24,000-30,000 people in South

Carolina. Estimates of the cost of this disease to this country last year alone range from 25-50 billion dollars. It causes approximately 120,000 deaths per year and is considered to^{be} the fourth most common death in the United States.

What is Alzheimer's Disease? Alzheimer's Disease is a progressive organic brain disorder that usually affects people over the age of 65. I say "usually" because it is estimated that there are approximately 80,000 people under the age of 65 with the disorder. However, the only risk factor that has clearly been identified with this disorder at this point is advanced chronological age. While there are numerous hypotheses regarding the cause of the disease, including (1) slow-growing virus; (2) chemical deficiency; (3) genetic defect; (4) immune system defect; (5) build-up of toxic materials such as aluminium, no definitive risk factor other than advanced age can be identified.

The disease is insidious and usually starts with minor memory loss and confusion. As the disease process progresses, the victim has difficulty with judgement and social skills, becoming unable to be employed or to perform home maintenance tasks. Physical problems eventually lead the person to be unable to walk, dress, bathe or feed himself. In the last stages of the illness, the person is completely bedridden, unable to recognize family, unable to speak and possibly being tube-fed and totally incapacitated and in need of twenty-four hour nursing services.

Due to advances in medical technology, the proportion of the elderly in the general population will continue to rise. It is now known that the fastest population subgroups growth in this country is in the age group over 80. Mortality rates are declining; a 65-year-old female in 1960 could expect to live 15.8 more years; by 1983 she could anticipate living an additional 19 years. The incidence of Alzheimer's Disease will surely increase.

South Carolina not only is experiencing growth in its elderly population due to longevity patterns, but also because of migration patterns. People are coming to our beautiful state because of climate and other desirable living features. We certainly are facing what has been described in some circles as an Alzheimer's Disease epidemic.

There was indeed a need to have a group in our state to study Alzheimer's Disease. This committee has been active since its formation. Some of the highlights include:

1. Provided support of the following Bill which was passed by General Assembly:
 - A. To allow a nonrefundable state income tax credit of twenty percent, not to exceed three hundred dollars, for expenses paid by the taxpayer for his own support or support of another to an institution providing skilled or intermediate care. No credit is allowed for expenses paid from public source funds.

House Number - 3218

Senate Number - 778 (as amended).
2. Provided assistance in planning the 1986 Aging Network Conference (held April 24-25) sponsored by the South Carolina Commission on Aging, which focused on Alzheimer's Disease and Related Disorders;
3. Made available a booklet entitled "Understanding and Caring for the Person with Alzheimer's Disease" to Support Groups, Councils on Aging, Area Agencies on Aging and institutions;
4. Conducted a statewide study on Support Groups;
5. Produced a slide/tape presentation on Alzheimer's Disease and Related Disorders which is available to Support Groups, community groups, agencies, and churches;
6. Participated in a presentation entitled "A State Initiative on Alzheimer's Disease" at the Southeastern Area Agency on Aging Conference in October 1985;

7. Presented an Issue Paper at the Public Hearing of the Legislative Study Committee on Aging in October 1985;
8. Participated in the first statewide conference on Alzheimer's Disease in November;
9. Investigated the feasibility of an Alzheimer's Disease Registry.

Activities planned for the current year include formation of a nursing home subcommittee to make recommendations regarding long-term care for Alzheimer's victims, providing support for the second statewide conference on Alzheimer's Disease November 14, calling a meeting of representatives of the 22 support groups around South Carolina October 18, 1986. It is out of this meeting that we plan to begin the process of establishing statewide priorities and developing specific legislative recommendations.

In closing, I encourage you to lend your support to our endeavors to find solutions to this dreadful disease that robs a person of all human dignity, that financially depletes a family's resources, that forces a family to endure a funeral that never ends.

October 1, 1986

Dolores Macey

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ALZHEIMER'S ADVISORY COMMITTEE

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TESTIMONY
PRESENTED TO
THE STATE OF SOUTH CAROLINA
STUDY COMMITTEE ON AGING
BY

SUE L. SCALLY
VICE CHAIRPERSON
S.C. COMMISSION ON AGING
ADVISORY COMMITTEE ON ALZHEIMER'S DISEASE AND
RELATED DISORDERS INITIATIVES

Last year I appeared before you to present a legislative issues paper that had been developed by our State Alzheimer's Advisory Committee. This year, I am very pleased to come back to you to thank you for the support you gave those initiatives in last year's General Assembly.

Act 472 of 1986 provides a tax credit for intermediate or skilled level nursing home care for up to 20% of the cost, not to exceed \$300. Passage of this act gave a signal to families in South Carolina that their financial struggle to provide care for their family members in institutions was not going unrecognized and that the State was willing to provide some tax relief for their efforts.

Section 174 of Part I of Act 540 of 1986 directed the Joint Legislative Health Care Planning and Oversight Committee, in conjunction with this Committee, to review state nursing home regulations, policies on health care financing and reimbursement, and policies on services to Alzheimer's victims in order to identify policy changes needed to improve care of these persons. In response to this directive, Dr. Dave Murday and his staff have prepared an excellent summary of the current status of State policy and programs. Our committee strongly endorses the recommendations contained in that report. We will be working over the next few months to prioritize those recommendations in order to focus our advocacy efforts.

As Dr. Murday documents in his study, the needs of Alzheimer's families are many and we must move on several fronts simultaneously: financial assistance and relief, service development, emotional support, education and research. We commend this Committee for your concern and leadership. We urge you to carefully consider Dr. Murday's recommendations as well as Ms. Seigler's previous request for community service funding and to proceed with implementation with a real sense of urgency. The numbers of affected persons--victims and family members--are growing geometrically with our aging population. Alzheimer's Disease is a national and state problem that will not go away; it demands innovative systems of health care and social services and a resolve to commit necessary resources.

For your information, I am attaching a copy of the National Alzheimer's Disease and Related Disorders 1986 "National Program to Conquer Alzheimer's Disease." *

Thank you for your past and continued efforts to assist families affected by Alzheimer's Disease.

*On file in the office of the Committee.

10/01/86

Kay Jamerson-McDonagh
SC Assoc. of Council on
Aging Directors
P.O. Box 832
Sumter, SC 29150

Presentation to the Joint Legislative Committee

October 1, 1986

President Kay Jamerson-McDonagh

South Carolina Association of Council on Aging Directors

As President of the S.C. Association of Council on Aging Directors, I appreciate the opportunity to appear before you today to present the testimony on behalf of 38 of the 46 Councils on Aging throughout the State. Councils on Aging are a part of the network created by the Older Americans Act and State legislation to serve the needs of the State's older population. Councils on Aging along with Area Agencies on Aging and the S.C. Commission on Aging have been assessing needs, planning and implementing services, and delivering in-home, supportive and nutritional services throughout the state for over a decade. We realize that our remarks would have a greater influence coming from older persons in need themselves or through your personal visit to the homes of older persons. Since that is not possible today, we hope we have done the next best thing by bringing slides as examples of the points we intend to make.

Each of you have played an important part in the success of aging programs in South Carolina and in the lives of older persons through your diligent efforts on this committee. We thank you for your past involvement and we look forward to working with you in the future to continue improving life for older persons in South Carolina. Through your efforts and those of the State Legislature, the S.C. Commission on Aging, Area Agencies on Aging, Councils on Aging and other aging service providers, services and programs for

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older persons have had great success in the past. Through the network, health and wellness programs in Multi-purpose senior centers have been created statewide producing preventative programs for seniors so that they stay healthier and thus, less likely to become dependent on state or federal benefit programs. Housing projects have been constructed that replace sub-standard living conditions for elderly and provide a supportive, safe living environment. Self-help groups have been created involving thousands of senior and other volunteers helping frail or impaired elderly in their homes thus saving countless tax dollars. Over 3,925 volunteers worked in the network last year producing a dollar value of \$786,000. Employment and training programs have been initiated to train, re-train, or place older persons in income producing employment or in changing careers. Direct services have been provided to thousands of older persons who would probably have been placed in institutions, many of whom would have required assistance from already over burdened benefit programs. In fact more than 51,000 older persons are scheduled to receive help from the network this year in direct service programs.

The success of the network has been difficult and does not promise to get any easier in the future. Decreasing funds for services, increases in the older population, more impaired clients at home as a result of changes to Medicare regulations, influx of more older persons into the state for retirement, and increases in the number of persons classified as old, old all combine to verfiy

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the urgency of our appeals to you today.

In addition, We are not meeting the current needs of the population of older South Carolinians. According to statistics prepared by the S.C. Commission on Aging, over 19,000 older persons are not being served who need help in at least three of the routinely accomplished things that you and I do every morning. That means that only half of the people that need help are receiving it. A 50% grade when I was going to school was a flunking grade. With the help of you and the General Assembly, the network can narrow the deficit.

We feel, therefore, that we should have one priority facing us and that is to establish a policy and practice in South Carolina for aging programs that both addresses the current needs of the older population and prepares us for the future explosion of aging persons. We must play both catch up and preparation for the future in the same game. We need your help and everyone else's help if we are to succeed. Our intentions are to help South Carolina meet our responsibilities for our citizenry in the confines of the reality of stressed state and federal revenues.

Inorder to accomplish this goal, Councils on Aging in South Carolina are asking your support of two efforts:

1. Permanent designation of Bingo tax revenue to the Aging network for the provision of community services; and,
2. Increased authority in State legislation for coordination efforts mandated by the S.C. Commission on Aging, Area Agencies on

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Aging, and Councils on Aging.

Permanent designation of the Bingo tax revenue would increase the States current commitment to the Community Services program to approximately 2.6 million dollars. This commitment is an increase from the existing \$250,000. We support the efforts presented by the Commission on Aging to increase the state's support of the community services program and feel that the bingo tax revenue would be an excellent resource for permanently establishing a funding mechanism. Other states have been extremely successful in establishing a long range commitment to aging services through similar arrangements utilizing entertainment (leisure) taxes, or paramutual betting, or similar devices. We have obtained a copy of the Pennsylvania Commonwealth's legislation for their lottery as an example. A copy of that legislation is attached to this testimony.* Our association also commits itself to assisting you and your staff to produce appropriate legislation to be submitted next legislative session.

Secondly, we feel the mandate from the Older Americans Act for the State Unit on Aging to plan, coordinate, and implement services for the states older population would be greatly enhanced through the strengthening of its authority for coordination of services. State legislation should mandate that planning and delivery of all aging services should be provided in association with the aging network in South Carolina and in particular the S.C. Commission on Aging, Area Agencies on Aging and Councils on Aging.

*On file in the office of the Committee.

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This does not mean that all funds for aging services must flow through the network or that all programs must be delivered by the network. It does however mean that any agency providing services, funding, planning etc. for older South Carolinians must work with the network. Statistics, reports, funding amounts, proposed services, etc., must have a single place where the overall state plan comes together. Otherwise duplication of effort, duplication of services, and the potential for waste in money will remain. The time is at hand and of the essence for all of us in South Carolina to have a long term commitment to a policy for aging which can only come about through a coordinated effort and a single authority.

Councils on Aging in South Carolina continue to grow, mature and have a more significant impact on the lives of older persons. We have had inspiration and a renewed dedication to our purpose through the recent appointment of new leadership at the Commission. We are grateful for the foresight and commitment the new leadership brings. And we are proud to be a part of the excitement and inevitable positive changes to take place in the network. With your help we will establish the long overdue policy and unite all forces concerned with the state's older population. We will meet the challenge of the present and the future.

Thank you very much.

Kay Jamerson-McDonagh
President, SC Association of Council on
Aging Directors
Sumter County Council on Aging
P. O. Box 832
Sumter, SC 29150
(803) 773-5508

Presentation Before The Joint Legislative Committee On Aging

By: Fletcher Spigner, Executive Director

Council on Aging of the Midlands

October 1, 1986

I do want to express my sincere appreciation for this opportunity to make a few comments. I am here today to advocate for older people and to advocate for older people.

My name is Fletcher Spigner, and I am the Executive Director of the Council on Aging of the Midlands, located here in Columbia. The Council on Aging was chartered in 1967 to serve senior citizens, and today it boasts the state's largest operational budget among all aging service organizations. I feel that we have been leaders in providing many services to older people at the local level through many successful and creative ventures, and we have done this with the tremendous support of our Area Agency on Aging, the Central Midlands Regional Planning Council, and through the existing state agency network of services to older people.

I told you last year that I believe that the number one issue facing the aging program in South Carolina is what I call "effort, energy, and enthusiasm dilution." I still believe this, but what I want to do first here today is advocate for an essentially disenfranchised group of frail older people living in their own homes without the services they need to live out their lives in dignity.

Let's consider just one county, Richland County, which demographically more or less can represent the entire state.

There are 36,000 persons 60 years of age or older in Richland County. 8,200 are 75 years of age or older, and 30% of the 75+ population are poor, and 30% live alone.

The older we become, the more likely we are to die alone and in poverty. The older we get the frailer we become. Because of the nursing home bed shortage, some older people receive needed in-home services, and many do and die without them.

We are not painting an extremely serious problem because one does not exist now. However, in five or ten years, if our caring State and its local communities do not continue shifting more and more energy and resources to addressing the needs of frail, homebound older people, then we will have a serious problem to deal with.

In Richland County alone, 4,105 people have received a home visit to determine their needs. 3,200 of these older people need some kind of assistance, including but not limited to transportation, food preparation assistance, housekeeping assistance, bathing assistance, and dressing assistance. Of this number, 1,500, or almost half, are not getting one or more of these services that they need. Many go without hot baths or showers; do not get to the doctor when they need to; seldom, if ever, eat hot meals; lie around the house in the same night clothes day after day; and generally live in clutter and dust.

By the end of this fiscal year, we estimate that we will have identified an additional 500 people who need but are not getting services, bringing the total of these essentially disenfranchised, frail older people to 2,000. By the end of fiscal 87-88, we will have identified an additional 600 persons who need but are not getting these services, bringing our total to 2,600 persons in Richland County alone who are not living quality lives because services are not available to them.

As these people become older and more frail, the number of services they need will increase, and we are going to have a very serious problem

in five or ten years if more and more energy and resources are not directed toward this disenfranchised frail population .

I have said that we have an "effort, energy, and enthusiasm dilution" in this State. We have no fewer than six to eight major state agencies expending tremendous amounts of energy on behalf of older people. This fragmented effort by our State hurts the aging program very badly and just about has to be the most inefficient way of serving the most rapidly growing segment of our population . Therefore, I am recommending your serious consideration of a single State agency to administer services to older people, and I am recommending your serious consideration of a great new abundance of money to meet the needs of this growing population

We would correct a number of problems if a single state agency were designated and substantially funded to meet the needs of our state's senior citizens. There would no longer be a lack of coordinated leadership at the state level, where now only tunnelvision views of problems affecting older people exist. Each other agency, despite any new leadership initiatives the Commission on Aging might undertake, is concerned about its programs and services, and because of the fragmentation of effort, energy, and enthusiasm across the state, these agencies have become very frustrated in trying to meaningfully coordinate their efforts. It is a set up, in my opinion, of the new administration at the Commission on Aging to continue subtly supporting a fragmented system.

If there is one action that would unify our collective efforts, it would be to establish a single state agency. And if there is one action that would substantially strengthen our collective efforts, it would be to direct more and more resources to this essentially disenfranchised group of older people, ever seriously growing in number, and magnitude of need.

Cindy S. McIntee, Proj. Dir
Columbia Urban League,
Legal Services for the
Elderly
P.O. Drawer J
Columbia, SC 29250

TESTIMONY OF CINDY S. MCINTEE
COLUMBIA URBAN LEAGUE
LEGAL SERVICES FOR THE ELDERLY PROGRAM

The Columbia Urban League's Legal Services for the Elderly Program provides free legal services for the elderly in in the Central Midlands Region. We provide legal services for persons aged sixty (60) and over in civil matters. We draft legal documents, advise and counsel clients, and provide representation in administrative proceedings. During the past year we have provided direct legal assistance to over 300 persons and provided legal workshops for over 400 persons. Without our service the majority of the senior citizens would not have obtained legal representation because they lack the necessary funds since they are living on fixed incomes. Because we deal with the elderly on a daily basis we are able to learn of many of the problems that they are confronted with.

One of the major concerns for the elderly is the ability to obtain the necessary funds so that they can remain self sufficient. Because of these concerns we are committed to helping seniors maintain and acquire governmental benefits, including Social Security Retirement and Disability. As you are probably aware, South Carolina is one of the states in which the Social Security Administration has an attorney present at its hearings to represent the Administration. It is therefore, crucial for the person who has been denied benefits to have legal representation. Legal representation may many times be the key to securing an income that is sufficient to provide for the basic necessities of life.

We are increasingly concerned about the atrocious living conditions that the elderly are relegated to when they suffer from domestic abuse. Although the State has systems in place to protect the elderly many of them are not aware of the protection that the law can provide. It is essential for us to speak out loudly and clearly about the crimes that are being perpetrated on grandmothers and grandfathers in our communities and let them know that physical and emotional abuse will not be tolerated. Unfortunately because of the lack of awareness many seniors live in fear, not knowing that others are suffering as they are.

The elderly are also the victims of countless frauds. They are oftentimes easy prey for the con artist as well as the unscrupulous businessman. Senior citizens have been defrauded in the areas of insurance, land, home improvements and consumer goods. Many seniors are hesitant to take legal action against persons when they are the victims of fraud.

We must let them know that there are methods for dealing with people who willfully take advantage of them and they should legally pursue action to prevent the spread of fraud. It should also be made clear that the state of South Carolina will punish persons who victimize the elderly.

The SC General Assembly is to be commended for its passage of the Probate Code. It should help to ease many of the problems that the elderly confront when they must deal with the administration of the estate of a loved one. Unfortunately many seniors do not realize how important a will is and their spouses and/ or children become embroiled in a terrible family and financial situation upon the death of the person. We are continuing our efforts to provide information about the problems of intestacy to the seniors in this area.

Continuing education is also needed to make the elderly population aware of the need for a Power of Attorney. Most people will become incapacitated before their death and need the services of a trusted family member or friend to handle their affairs. Many times people do not seek an attorney's assistance before they become incapable of executing a Power of Attorney and because of that they must address the cumbersome battle of having a Committee appointed by the court. This problem is of special concern to people who are afflicted with Alzheimer's Disease.

More and more we are confronted with the problems of a senior citizen who needs help in obtaining a divorce. Because we do not handle divorces and Legal Services only handles a limited number of divorces these people are trapped in an unfortunate situation. Besides the mental anguish that normally accompanies a divorce they have the financial burden of trying to secure a lawyer with their limited funds. Many times the seniors are stuck in the situation because they simply can not afford to do anything about it.

We are pleased that our state has made a commitment to providing legal services to the elderly and has passed needed legislation such as the new Probate Code, the Landlord-Tenant bill and extension of the Homestead Exemption. Unfortunately there are many seniors who go without legal representation when trying to secure governmental benefits, divorces, wills and deeds because they lack the resources and we lack the resources to meet the needs of so many people. We must remain committed to those persons who have built our communities, our towns, cities and state and provide them with a way of life that is safe, secure and happy.

10/1/86

- Dr. Parrish - Ms. McIntee, one question. Would you explain to this Committee the extent to which the Urban League does or does not affiliate with the aging network?
- McIntee - We are affiliated with the Central Midlands region. We are a part of the service providers under the Central Midlands Regional Planning Council. So we are a part of the aging network.
- Parrish - You are not in isolation.
- McIntee - No. We work closely with the Councils on Aging throughout Richland, Lexington, Fairfield, and Newberry Counties.

Jean Buck, MSW
Greenville Hospital System
701 Grove Rd.
Greenville, SC 29605
012-195

TO: Joint Legislative Study Committee On Aging

FROM: Upstate Social Workers Concerned With Nursing Home Placement
For The Elderly

We respectfully request your attention to the following concerns:

NURSING HOME PLACEMENT FOR MEDICAID PATIENTS

Conflict over Medicaid reimbursement has been going on for some time. As a result, Medicaid nursing home placement in South Carolina has become increasingly difficult. Nursing home placement has been impossible for some Medicaid patients. Some South Carolina residents have been placed in nursing homes in other states or in areas distant from their homes and families. This can be emotionally and financially devastating to the elderly and their families.

\$25 Medicaid Personal Allotment

This allotment, originally designated for incidental needs of nursing home patients (hair cuts, laundry, etc.) has not been adjusted since it was established years ago. Cuts in Medicaid coverage since that time have forced families to use this allotment to fill gaps in Medicaid coverage, especially for medications. This has resulted in unreasonable financial burdens on families of Medicaid nursing home patients.

PATIENTS WITHOUT RESPONSIBLE PARTIES OR FAMILY SUPPORT

As previously stated, Medicaid nursing home patients' expenses often exceed the \$25 personal care allotment. Nursing homes can not be expected to absorb these expenses. Families or responsible parties usually must agree to pay the patient's expenses over the \$25 before a Medicaid patient can be admitted to a nursing home. There are no provisions for patients without responsible parties or to assist families unable to bear this financial burden. This makes placement of this segment of the population virtually impossible.

As you can readily see, these problems present major obstacles to efficiently planning for our elderly citizens. We invite your close consideration of these identified problem areas, and will be glad to assist you in any way possible.

We, the undersigned, support the presentation of the attached problems related to the elderly for your consideration.

NAME

Barbara G. Jones

Nelle B. Taylor

Deborah M. Simmons

Andrew L. Lutz

A. B. G. G. G.

Cathy Graham

Jacqueline Lee

W. A. Porter

K. A. G. G. G.

Michael H. G. G.

Patricia M. G. G.

Barbara B. G. G.

Lyn M. G. G.

Cynthia L. G. G.

Paul C. G. G.

Julie C. G. G.

Susan G. G. G.

L. G. G. G. G.

Kimberly G. G. G.

Christine G. G. G.

AGENCY

Strand Memorial Nursing Home

Strand Memorial Nursing Home

Strand Memorial Nursing Home

Greenville Memorial Hospital

Greenville Memorial Hospital

Greenville County DSS

Roger C. Place Hosp.

Piedmont Nursing Home

Eastman Healthcare, Inc.

Greenville East Nursing Center

L. G. G. G. G.

V. H. G. G. G.

Greenville Memorial Hospital, Inc.

Greenville Memorial Center

Greenville Memorial Center

Roger C. Place Nursing Home

Allen Bennett

C. H. G. G.

Piedmont Nursing Home

Greenville Memorial Center

We, the undersigned, support the presentation of the attached problems related to the elderly for your consideration.

NAME

Sherril L. Forehand

Bina Reib

Chris Strohmman

Amela Hanepta

Cecilia Pitts

Sally G. Schumacher

Patsy Whitfield

Janet Stewart

Julie Carter

Susan Graham

Jean Buck

Peggy Strawn

Jay Messer

Michael McLeod

AGENCY

Greenville Memorial Hosp.

GHS

GHS

GHS

GHS

St Francis Hospital

Ellenburg Nursing Center

Ellenburg Nursing Center

Rogers-Huntzger Nursing Center

Allen Bennett Memorial

Greenville Memorial Hospital

Greenville Memorial Hospital

Greenville Memorial Hospital

Boys C. Place

Rep. Blackwell - Ms. Buck, I have been looking at your statement as you read it and I noticed the signatures on it and I noticed that you are saying that nursing home placement has been impossible for some Medicaid patients. And signed to it are the names of some folks representing certain nursing homes that won't even take Medicaid patients even though the beds have been allocated to them under Certificate of Need program. Now you're coming in here telling us that there are problems. Do you have any solutions for us? What do you want us to do? You folks won't take patients. How can we do anything but send them out of state?

Ms. Buck

- I think what I'm trying to do is just to make you all aware of some problems we identified. We didn't try to find reasons for it or to place responsibility. These were just problems that we identified and we were hoping that possibly a study group could be established to look into these. We don't have recommendations. We just see the problems.

Mr. Chairman, members of the Committee - Thank you for allowing me to present a few of my concerns to you. I have several issues that I would like to bring to your attention today.

Through the hard work of this Committee, the Living Will was passed during the last legislative session. As you will remember, one of the provisions of this act was to require that one of the witnesses had to be an Ombudsman or a person designated by the State Ombudsman. You may be interested to know that this has been a good provision as we have had cases where our office was called to notify that a patient wanted to sign a Living Will; however, when my staff arrived at the facility and had conference with the patient, we were told by the patient that they did not want to sign the will. There have been many patients who did want to sign. We have witnessed approximately 40 wills and they represent all classes of people. It took several years for it to pass the General Assembly. However, our experience tells us that it was the correct thing to do, especially from the standpoint of the elderly.

The next item that I would like to discuss is the need for more Medicaid nursing home beds. Last year, Representative Blackwell, you remember, legislation was introduced to free up beds; however, because of the Health Care Association, the legislation remained in committee. This legislation is needed. Why the Association will not support this is a mystery. Only last week I was informed that a home, which has all of their beds certified for Medicaid, yet has ten (10) empty beds,

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we were informed that these are private pay beds. Folks, there is something wrong here, when there are many Medicaid patients waiting on beds. I urge you to help relieve situations such as this. There are other facilities also holding beds.

There is a similar type situation with hospital swing beds. Approximately 240 beds are certified to accept Medicaid patients; however, only approximately 25 beds have been utilized. If these beds are not going to be used, then the Health and Human Services Finance Commission should transfer these funds to where they could be used for new Medicaid beds.

Another area that has caused great concern and resulted in our office and probably yours to receive many calls, is the criteria that the Health and Human Services Finance Commission is using to determine levels of care for nursing home patients. I met with several of the Finance Commission staff concerning this problem; however, I do not see much progress on getting the situation corrected. I will be the first to acknowledge that patients need to be reviewed and those who do not need nursing care should not be there; however, the criteria that is currently being used is more strict than is required by federal regulations. This has been acknowledged by the Finance Commission. Patients are being forced to go to boarding homes that do not have the ability or the staff to give the care that is required by most of the discharged patients. It would

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appear that the criteria needs to be more lenient until the boarding home study currently being conducted is completed. I recommend that this Committee contact the Finance Commission and request the Level of Care criteria be amended to prevent patients from being transferred to inadequate facilities.

Another factor that is affecting the boarding home situation is the Department of Mental Health in their quest to lower the census at State Hospital and Crafts-Farrow by placing large numbers of patients in these facilities. The combination of these two factors has placed a burden on these facilities that is an injustice to the residents.

Both the Level of Care reviews and the discharge of the mental health patients are needed; however, too much is happening at the same time. There needs to be better coordination between the agencies. Another agency that has been affected by the above plans is the Department of Social Services. As you are probably aware the optional supplement budget of D.S.S. is under-funded.

The Adult Protective Services legislation needs to be amended. The staff of D.S.S. and I plan to submit draft legislation to you that will amend the Adult Protective Services statute. During the past several months, there have been situations where patients needed an operation and had no relative to give

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permission for the operation. The situation remained unresolved until the patient's condition became life-threatening. Then, the physician performed the operation. This type of situation needs to be corrected -- patients should not have to wait until their lives are threatened before receiving the needed medical treatment.

There is also a need to amend the section of the code as it relates to exploitation. The current statute is vague and most difficult to enforce.

Many states have a statute that is commonly referred to as the Receivership Law. There are times when a nursing home does not meet federal standards which results in the patients having to be moved to another facility. When a state has a Receivership Law, the state appoints a person or group to operate the facility until new operators can be brought in or until the problems are resolved. This statute would prevent patients from being moved.

The last item I would like to discuss is the loss of federal funds that has caused our Volunteer Ombudsman Programs to be discontinued in all but one area of the state. Programs in Anderson, Greenville, Spartanburg, Richland and Lexington were not renewed this year. In the past, our office has received funds from the Commission on Aging to fund a part-time staff

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person in these areas. Most of these programs were funded with carryover funds from the C.O.A. It would take approximately \$30,000.00 to reinstate these local programs. I realize this is a very austere year; however, I would hope that somewhere funding for these programs could be found. Having Local Ombudsmen has proven to be a most worthwhile Program. I have in my hands a petition signed by many people attesting to the need for the Local Programs. I might add this petition was spontaneous and not solicited by our office.

Thank you for letting me express a few of my concerns.

Attachment*

*On file in the office of the Committee

- Rep. Waldrop - Back up and restate what you stated that the hospitals are not cooperating. Is that what you're saying?
- Bradley - Yes sir. They are not admitting patients when being asked to admit patients. These are the small hospitals that have been certified to handle Medicaid persons and yet they are not admitting them. In July, 11 patients were billed to the Finance Commission and in August, 12 patients were billed. So out of 239 beds, 33 were used.
- Holler - Do we need legislation or do we need some authorization from a superior?
- Bradley - I'm not sure that I can give you an exact answer, but I would assume since these hospitals sign a contract with the Finance Commission, I would hope that through that contract something could be worked out. I don't think you have to legislate everything. Since they do sign a contract I would hope we could work something out through the contract.
- Rep. Harris - You gave a figure of 649,000 new dollars that they are asking for this purpose.
- Bradley - Yes sir. That is in the current budget you will be acting on in January.
- Dr. Parrish - The problem is specifically for Medicaid. So Medicare for the elderly is not a problem?
- Bradley - Well, that is a whole new ballgame. Medicare is almost nonexistent so far as nursing home payments are concerned anymore. Medicare only pays the full cost of the first 20 days and then starting on the 21st day, the deductible is \$61.50 and come January the deductible is going to be \$71.50 which is approximately \$30 more than our statewide average. In all due respect after the 20th day, Medicare is absolutely no use to the people in South Carolina.
- Dr. Parrish - So we have a problem insurance-wise as well as with hospitals.
- Bradley - Yes sir. The federal government through their magic formula that they have, they continue to raise the cost to be admitted to a hospital. You have to pay a deductible of \$542 and that's going up. So Medicare is nonexistent as far as I'm concerned in serving the needs of elderly in Long Term Care facilities other than paying doctor visits once a month.

- Rep. Waldrop - Are you stating that the nursing home association is not cooperating with you.
- Bradley - I didn't say the Nursing Home Association. I said the Finance Commission who sets the criteria.
- Rep. Waldrop - Earlier you mentioned Mr. Lee's name. Would you retract that or go back to it.
- Bradley - What I said was that last year when the legislation was introduced by Rep. Blackwell to where we could withdraw unused Medicaid Beds, in other words, the legislation basically said that homes could choose the number of private pay patients they wanted and that would free up the Medicaid beds that we had certified. That legislation did not get out of Committee because the Health Care Association was opposed to it and Mr. Lee is their Executive Director and Randy knows that and I'm not faulting Randy. As Executive Director, he is following his orders but I'm saying that the Association does not want the legislation that Rep. Blackwell introduced and that I feel like it would help relieve some of the Medicaid situation because we, DHEC, could reallocate Certificates of Need and let people have additional Medicaid beds.

Johannah Gold
Site Manger
P.O. Box 283
Mt. Pleasant, SC 29464

Good morning, I am Johannah Gold. First let me apologize for not being on time. I got lost. So that's why I'm late. One of the main things I learned in school if I didn't learn anything else is to be on time. Please accept my apology.

I will read the letter I submitted to the Committee along with the letter written by Richard Jones, Mayor of Mt. Pleasant.

Johannah G. Gold
Site Manager
P. O. Box 283
Mt. Pleasant, South Carolina 29464

September 4, 1986

Ms. Keller H. Barron
Joint Legislative Study Committee on Ageing
P. O. Box 11867
Columbia, South Carolina 29211

Dear Ms. Barron:

I am concerned about the Senior Citizens who are alone all day until their loved ones return from their daily occupations. These Seniors should have some place to go every day, and be supervised, and by doing this the families could be more productive on their jobs, knowing they are cared for.

This will require a central location where both groups can meet. The Active Seniors will be required to spend four hours; the others will stay from nine to five, five days a week.

This will require staff members, a van with a lift; we also need appropriations from the Town of Mt. Pleasant for expenses. Some cities do not include the Senior Citizens in their yearly budget; but after all we are taxpayers too.

Also during the Summer months, you can also get students from the college majoring in Gerontology to get involved in the uplifting of our Senior Community.

Thank you for your help, because I feel sure you will help us reach our greatest potentials in the years to come. Looking forward to hearing from you soon, concerning this matter.

Sincerely yours,

Johannah G. Gold, Site Manager

cc: Clyde Dangerfield, State Representative
Mayor Richard L. Jones



SEP 11 1986

RICHARD L. JONES
MAYOR

OFFICE OF THE MAYOR
POST OFFICE BOX 745
MOUNT PLEASANT, SC 29464

September 10, 1986

Ms. Keller H. Barron
Director of Research
Joint Legislative Study Committee
on Aging
P.O. Box 11867
Columbia, South Carolina 29211

Dear Ms. Barron:

The Town of Mt. Pleasant's Town Council and I am deeply concerned about our Senior Citizens.

We currently provide our Senior Citizens with a facility, with heat and air, that will handle approximately 75 comfortably. They meet three times a week. The Town has been furnishing a vehicle to pick up many of the participants. Mrs. Joan Barnes has worked very closely with our program. She currently provides a supervisor and a driver for this program.

The Town of Mt. Pleasant gives the Senior Citizens \$125.00 per month towards the purchase of food to help feed our citizens.

We seriously need assistance to help provide a Van that can bring our Senior Citizens to this center.

As you are aware, the financial restraints that are placed on government are tremendous. We are requesting that your committee look at supplying the needs of transportation of our Senior Citizens.

If we cannot bring our citizens to these centers, how valid is any program if the individuals cannot attend?

Ms. Keller H. Barron
Director of Research
Joint Legislative Study Committee on Aging

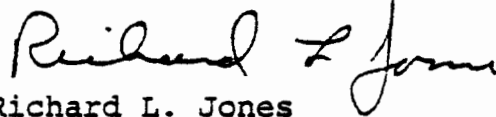
Sept. 10, 1986

We realize your job is tremendous but we would appreciate any consideration you could give us.

We have some dedicated individuals who contribute greatly to this outstanding program.

If I can be of any assistance or you need further information, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Richard L. Jones".

Richard L. Jones
Mayor
TOWN OF MOUNT PLEASANT

CC: Joan Barnes
Johannah G. Gold
Clyde Dangerfield
Arthur Ravenel

RLJ/ssh

Now the Town of Mt. Pleasant has only provided a car which can only bring five seniors to the center at a time. We really need a van so that we could get all our seniors there and they can participate.

Now they said they'd give us \$125.00 and they did. But not until after I went to the Town Council and let them know that I had served 2511 without any help except what the senior citizens themselves provided. I made them understand. I motivate them in a way that they didn't have to stay and wait for something to help us. We were trying to help ourselves and that's what we did. And this \$125 was only given to us July 1st. The only thing the town gave us was facilities but can you imagine a senior at the door around 10:30 in the morning and the outside is already 100 degrees and she can't come in and she has to trek all the way back home. It's pitiful. It's heart rendering. Not only that, we have to share that facility with the others in the community. We have a frigidaire in there. If we leave anything for the next day, anybody who uses that facility overnight, they take it away from us. Over the weekend, if they use anything over the weekend, we just don't find it there on Monday.

Now what we really need more than anything else is a van to pick up all these ladies at the same time. You can imagine, I leave my house at 8:00 in the morning and I don't get back until 4:00 in the afternoon. All that is volunteer for these ladies and I wish you would look into this. I would appreciate it because we really need help. And one of the things I have explained to them is that just because they are senior citizens, it doesn't mean they have to get in a rocking chair and wait for the inevitable because that's going to come anyway. Try to help yourself and if you try to help yourself, I'm quite sure others will help you. Thank you.

TESTIMONY TO THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

October 1, 1986

**Dolores F. Wilke, Director, Division of Community Long Term Care
S.C. State Health and Human Services Finance Commission**

Representative Harris and members of the Study Committee on Aging, thank you for your continuing support of the Community Long Term Care Program. I appreciate this opportunity to testify as a representative of the S.C. Health and Human Services Finance Commission about the present status and future directions of the Community Long Term Care Program (CLTC) and other related long term care issues.

The major thrust for the CLTC Program in FY 85-86 was directed toward implementing the new home and community-based waiver services, enrolling clients in the expanded Medicaid eligibility category, and resolving issues related to the complexity of the CLTC federal waiver, under which the program operates.

During the year, one hundred new providers of home and community-based services were enrolled and trained. CLTC service managers received extensive training in level of care determinations and case-management as related to the new services. Over 14,000 persons who applied for Medicaid-sponsored long term care services were screened, and over 5300 persons received case management and other home and community-based services under the CLTC Program.

Extensive efforts were made to build relationships and coordinate services with other agencies and programs which serve the elderly and disabled populations. CLTC strives to utilize the waived services to fill in gaps in the service system and not to supplant or duplicate services. Informal caregivers and service providers including the family, churches, civic clubs and other volunteers are given assistance and encouragement to provide as much help and support to clients as possible before CLTC services are authorized.

This fiscal year will be devoted to evaluation, fine tuning, and planning future directions for the program. Quality assurance, utilization review, provider development and data management are targeted areas to be refined. The waiver must be renewed by October 1, 1987. Therefore, staff will also be concentrating on the work required to assure that a new waiver is granted by the Health Care Financing Administration.

There is expected to be a short fall in our service dollars in this fiscal year. CLTC served the maximum population permitted under the waiver in the last fiscal year and is expected to do the same this year. Increased service dollar funds and operating funds for the service management contract have been requested for FY 87-88.

The second area I would like to bring before you is the need to establish a mandatory pre-admission screening program for all persons entering nursing homes. Community Long Term Care currently screens all persons who apply for Medicaid-sponsored long term care. During this screening, the individual is assessed by a service manager and a determination is made as to whether or not the individual meets the level of care criteria for Medicaid. If the individual meets the criteria, he is informed of community services and other assistance which could be available to him if he chooses to remain in the community. The individual is also informed of the services available in the nursing home and is offered the choice of entering the nursing home or remaining in the community. There is also an option of entering a nursing home for a specific period of time for rehabilitation or intensive treatment with the option of returning to the

community when his condition improves or support services can be put in place. If this option is chosen, CLTC will work with the family and community to pave the way for the individual's return to the community.

Persons who enter the nursing home as private pay, Medicare or other payment source and who have not applied for Medicaid do not have these options presented to them. When these persons exhaust their financial resources and apply to convert to Medicaid, they are given the option of remaining in the nursing home or returning to the community. However, it is difficult to assist these individuals in returning to the community when in many instances their home and/or belongings have been sold or their apartment relinquished, and their community support system has disintegrated. Possibly, admission to the nursing home could have been delayed or prevented if the individual or their family could have received assistance prior to admission.

In many cases these individuals have been determined ineligible for Medicaid sponsored long term care because they do not meet the level of care criteria. When this happens it is traumatic for the patient and the family.

The results of a recent study of persons screened during 1985 by CLTC, who had applied for Medicaid sponsorship in a nursing home and were converting from private pay or other payment source, showed that out of 2511 persons who converted to Medicaid, 2262 converted within the first three years of admission. Of these, the average length of stay before conversion was 163.5 days.

A screening program for all persons seeking long term care services regardless of their expected payment source could help many of these individuals delay or avoid entering the nursing home. Their resources might last longer if they remained in the community, with case management and other home and community-based services, thus delaying the need for Medicaid sponsorship of their care. Most current providers of CLTC home and community-based services would be able to serve the private pay population. Case management could be offered on a fee-for-service basis by CLTC.

Legislation is needed to implement this mandatory pre-admission screening for all persons. I would like to request that the Study Committee work with the HHSFC and other interested parties to introduce and pass this legislation during the next legislative session. Eight other states including Georgia, Illinois, Indiana, Minnesota, Nevada, New Jersey, Virginia and Delaware have mandatory pre-admission screening for all persons. In some of these states the individual requesting long term care screening, pays the cost of the screening. This would offset the increased cost for implementing a mandatory pre-admission screening for all persons. The direct cost for a screening would be between \$60 to \$75 per person.

The third area I would like to address is the need for developing and implementing funding alternatives for financing long term care services in South Carolina. In trying to plan a continuum of care for the frail elderly and disabled, the first problem that one faces is the lack of dollars available to expand services or eligibility.

The majority of persons with long term care needs in South Carolina eventually look to Medicaid to pay for their long term care services. In addition, the demand for long term care services is also increasing. The fact that the South Carolina Health and Human Services Finance Commission administers the Medicaid Program and the Social Service Block Grant Program gives it a vital interest in instituting funding alternative in a time when both state and federal dollars are tight.

We would like to request that the Study Committee on Aging work with Health and Human Services Finance Commission in establishing an ad hoc study committee

dedicated to completing an in-depth study of long term care funding alternatives and mechanisms for implementing those alternative or programs which would be feasible in South Carolina.

I appreciate the opportunity to present this information and the concerns of our agency to you. The Health and Human Services Finance Commission is committed to working with this Study Committee and other concerned bodies in developing a viable long term care system for elderly and disabled South Carolinians.

03/18/86

NURSING HOME

CONVERSIONS FROM PRIVATE PAY TO MEDICAID
(3 Years or less)

| <u>Days under private pay</u> | <u>Percentage</u> | <u>Cumulative Percentage</u> |
|-------------------------------|-------------------|------------------------------|
| 30 days or less | 28.8% | 28.8% |
| 31-60 days | 14.0% | 42.8% |
| 61-90 days | 9.9% | 52.7% |
| 91-180 days | 12.8% | 65.5% |
| 181 days - 1 year | 20.4% | 85.9% |
| Over 1 year | 14.1% | 100.0% |

Average = 163.5 days

Sample Size = 2,262

03/18/86

NURSING HOME

CONVERSIONS FROM PRIVATE PAY TO MEDICAID
(5 Years or Less)

| <u>Days under private pay</u> | <u>Percentage</u> | <u>Cumulative Percentage</u> |
|-------------------------------|-------------------|------------------------------|
| 30 days or less | 27.5% | 27.5% |
| 31-60 days | 13.4% | 40.9% |
| 61-90 days | 9.4% | 50.3% |
| 91-180 days | 12.3% | 62.6% |
| 181 days - 1 year | 19.4% | 82.0% |
| Over 1 year | 18.0% | 100.0% |

Average = 218.8 days

Sample Size = 2,371

03/18/86

NURSING HOME

CONVERSIONS FROM PRIVATE PAY TO MEDICAID
(No Limit)

| <u>Days under private pay</u> | <u>Percentage</u> | <u>Cumulative Percentage</u> |
|-------------------------------|-------------------|------------------------------|
| 30 days or less | 25.9% | 25.9% |
| 31-60 days | 12.6% | 38.5% |
| 61-90 days | 8.9% | 47.4% |
| 91-180 days | 19.6% | 67.0% |
| 181 days - 1 year | 10.4% | 77.4% |
| Over 1 year | 22.6% | 100.0% |

Average = 373.9 days

Sample Size = 2,511

Rep. Blackwell - So you would say to them "We really don't think you need to go in but if you want to spend your money instead of going to a motel, you're welcome to go."

Wilkie - And we'd like to put some type of a penalty. If you're going to convert to Medicaid within 6 months or 1 year, you could not convert to Medicaid within that period of time.

Rep. Blackwell - Because you're spending resources that you really don't need to spend.

Wilkie - We would like that penalty but people would have the choice if they'd want to enter or not.

Sen. McLeod - What happened about that federal audit that I think they found about 100 ineligible and they were trying to get some money back. As a consequence of that I noticed they were attempting to move the number of people out that they found weren't qualified. What is the status on that?

Wilkie - We are still fighting them taking the money back. We're still going to lose some. We're trying to whittle it down some. The inspection of care is going in and looking at all clients in a nursing home and doing a level care decision. These are the people that Bill was talking about that have been discharged back to the community because they didn't meet the criteria. Right now there is over 100 that have been found that way. I would expect that for the first 6 months there will be large numbers of people that are found and there will be large numbers of appeals and it's going to be a problem. Once the inspection of care team gets through their full cycle in 6 months, there should not be this large number of people out there that have been in and are now ineligible. There will still be occasional people but it will not be this huge number that is now happening and being sent into the system that's not there to take them.

Dr. Holler - The point occurred to me that your agency probably ought to draw up that legislation. That is a very complicated piece of legislation you're talking about and it needs the insights that evidently you would have more of than any group around this table. And I'm sure that we could take a look at what you do and work with it a whole lot better than we could dream up what you have in your mind.

Rep. Harris - The staff and Ms. Barron will work with you on that legislation, Ms. Wilkie.

PRESENTATION: MEETING THE NEEDS OF THE MENTALLY ILL ELDERLY

TO: JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

BY: GERIATRIC SPECIALIST ADVISORY COUNCIL, DMH

DATE: WEDNESDAY, OCTOBER 1, 1986

CONCERN NO. 1 INTENSIVE CARE FACILITY BEDS FOR THE MENTALLY ILL.

BASED ON INPUT FROM OUR COUNCIL MEMBERS REPRESENTING THE COMMUNITY MENTAL CENTERS THROUGHOUT THE STATE, IT IS CLEARLY SUBSTANTIATED THAT MOST ICF BED RESOURCES ARE EITHER CRITICALLY LIMITED OR NONE EXISTENT TO ACCOMMODATE THE APPROPRIATE PLACEMENT OF THE MENTALLY ILL ELDERLY PATIENT. FOR EXAMPLE, IN ONE AREA ALTHOUGH LICENSURE INFORMATION INDICATES AN EXCESS OF 68 ICF BEDS, 57 MEDICAID PATIENTS WHO ARE MENTALLY ILL ARE WAITING FOR PLACEMENT. IN ADDITION, IT APPEARS WHEN SUCCESSFUL PLACEMENT DOES OCCUR THE PATIENT'S LENGTH OF STAY IS SO SHORT TERM (AVG. 10 DAYS) THAT THEIR CONDITION (WHICH HAS ALREADY BEEN DETERMINED TO REQUIRE INSTITUTIONALIZATION) WARRANTS THEIR PLACEMENT INTO THE MENTAL HEALTH FACILITY OF CRAFTS-FARROW STATE HOSPITAL INAPPROPRIATELY. THE ABOVE CONDITIONS, COUPLED WITH REGULATORY LIMITS OF 3rd PARTY PAYORS WITH REGARD TO COST OF NURSING HOME CARE FOR THE DEMENTED (ESPECIALLY THOSE DIAGNOSED AS ALZHEIMER'S DISEASE) HAS PLACED EXTREME BURDENS ON THEIR FAMILYS AS WELL AS THOSE SERVICE AGENCIES EXPECTED TO BE RESPONSIBLE FOR COMMUNITY CARE PROGRAMS AND REDUCING INSTITUTIONALIZATION OF THE MENTALLY ILL ELDERLY. THUS, WE STRONGLY RECOMMEND THAT THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING CONSIDER THE FOLLOWING:

1. REVIEW THE ICF BED AVAILABILITY CONDITIONS FOR THE MENTALLY ILL ELDERLY.
2. CONSIDER THE POTENTIAL AND PLAN FOR MODIFYING THE 3rd PARTY PAYOR RESOURCES OR A SPECIAL FUNDING PROGRAM FOR DEVELOPING THE NEEDED BEDS AND A METHOD FOR INDIGENT SUPPORT.

3. EXPLORE METHODS OF UPGRADING MENTAL HEALTH CONSULTATION RESOURCES TO MORE EFFECTIVELY PROVIDE PROFESSIONAL SUPPORT AND PATIENT MANAGEMENT CONSULTATION TO THOSE NURSING HOME FACILITIES WITH THE MENTALLY ILL ELDERLY PATIENT.

CONCERN NO. 2 DAY CARE PROGRAMMING FOR THE MENTALLY ILL ELDERLY

OUR EXPERIENCE WITH THE MENTALLY ILL ELDERLY HAS CLEARLY DOCUMENTED THAT THEIR PRIMARY CHARACTERISTICS OF BEING INEPTLY DEPENDENT, WITH MODERATE TO SEVERE CONFUSION, AND POORLY ORIENTED TO BASIC NEEDS ACHIEVEMENT, AND MINIMAL FAMILY SUPPORT OR RESOURCES FIND THEMSELVES IN A LOWER FUNCTIONING STATUS WHICH HAS IN MOST CASES PRECLUDED THEM FROM BEING DIRECTLY OR EXTENSIVELY INVOLVED IN THE USUAL COMMUNITY RESOURCES DESIGNED FOR THE ELDERLY. THIS SITUATION SUGGESTS THE NEED FOR THE DEVELOPMENT OF THE FOLLOWING:

1. DAY CARE PSYCHOSOCIAL PROGRAMS WITH ELEMENTS THAT SPEAK TO ISSUES OF THE ELDERLY PATIENT'S MANAGING BASIC CARE NEEDS, ADJUSTING TO AND USING COMMUNITY SOCIAL SUPPORT SYSTEMS AND PROGRAMS. CONNECTING TO AND MAINTAINING THE NECESSARY MEDICAL SERVICES AND LEARNING HOW TO BE AS INDEPENDENT AS POSSIBLE. (PRESENTATION OF MODEL PROGRAM IN LEX. CO.)
2. BOARDING HOMES THROUGHOUT THE STATE THAT CAN FACILITATE REHABILITATIVE AND STIMULATING OR COMFORTING ACTIVITIES IN ADDITION TO MAKING THE APPROPRIATE COMMUNITY CONNECTIONS.
3. HOMEBOUND PROGRAMMING AND PROFESSIONAL SERVICES AND/OR TRANSPORTATION TO THOSE IN NEED TO ACCESS THEM TO COMMUNITY RESOURCES. THESE ISSUES ARE VERY CRUCIAL TO THOSE IN THE MORE RURAL AREAS IN THE STATE.

THE FUNDING NEEDS FOR THESE PROGRAMS INCLUDE: A) DEVELOPING MECHANISMS TO PLACE THESE PATIENTS IN BOARDING HOMES; PAY FOR ACTIVITY THERAPIES WITHIN THE HOME: AND COST COVERAGE FOR MEETING THE PERSONAL NEEDS OF THE PATIENT.

B) ESTABLISH MECHANISMS FOR FUNDING A DAY CARE SYSTEM INCLUDING STAFFING, MEALS, FACILITY AND OTHER OPERATING EXPENSES. C) ESTABLISH MECHANISMS AND SOURCE OF FUNDS TO SUPPORT AUXILIARY PROFESSIONAL SERVICES NECESSARY TO MEETING THE BASIC NEEDS OF THE ELDERLY. D) ESTABLISH MECHANISMS TO FUND CRISIS AND RESPITE CARE OPTIONS DESIGNED TO DIVERT PATIENTS FROM INSTITUTIONALIZATION.

THE GERIATRIC SPECIALIST COUNCIL APPRECIATES THE OPPORTUNITY TO EXPRESS THESE CONCERNS AND NEEDS TO PROVIDE AS BROAD A BASE AS POSSIBLE IN GIVING EACH MENTALLY ILL ELDERLY PERSON THE MAXIMUM BENEFIT OF OUR EFFORTS AND RESOURCES.

J. Randal Lee, Exec. Dir.
SC Health Care Association
1122 Lady St
Columbia, SC 29201

I do apologize for not being here this morning but I did have another meeting. Senator Doar can verify that I was there and not at the golf course today.

Before I begin my remarks I feel compelled to address the remarks of an earlier speaker. Mr. Bill Bradley, State Ombudsman alluded to the fact that the Health Care Association kept legislation in a Committee. I want to set this Committee straight as to this fact, I do not vote in this General Assembly and I have never voted to keep a piece of legislation in this General Assembly. I have talked to the Chairman of that Committee and he feels that an apology is in order to his Committee members and feels that Mr. Bradley has insulted his Committee. And before I begin I wanted to get that straight. And if he does not understand why we did not support this legislation then he did not listen to me last year.

PRESENTATION TO THE JOINT LEGISLATIVE
STUDY COMMITTEE ON AGING

by: J. Randal Lee, Executive Director
South Carolina Health Care Association

Mr. Chairman, Members of the Committee:

I speak to you today on behalf of ninety-seven nursing homes in the State of South Carolina and I represent approximately 9,000 of our state's long term care beds. Over the past thirteen months I have had the pleasure of serving as Executive Director of the South Carolina Health Care Association. This has been quite an experience for me and with the help of many of the persons appearing before you today I have learned quite a lot about long term care in the State of South Carolina. I am not here today to tell you that we have a perfect system, but I am here to tell you about some things that I feel that are very positive. The long term care needs of the elderly in South Carolina are being met by state facilities, by my membership, by community long term care and by other programs that have been developed by the General Assembly of this state. We have room to improve but I submit to you today that those individuals receiving care from this state and from our membership are receiving quality care that is unmatched anywhere in the United States. I am very proud of my Association and its membership and the gains that we have made in the past year in the area of peer review and in other areas that directly affect quality care. Through efforts of our State Ombudsman and the State Licensing Board for Nursing Home Administrators those instances, if any, when problems do arise are dealt with swiftly and justly with the patients' well being placed above all else. I am here today to ask for but one thing — and that is increased funding and priority funding for long term care of the elderly in South Carolina. I am not speaking about the rate of payment per patient day but of the need to increase the number of Medicaid beds in the State of South Carolina, which can only be accomplished through increased funding. Leaders in the State Health and Human Services Finance Commission and legislative leaders have made the statement throughout the past year that they feel our current reimbursement contract is fair. I submit to you that if this is a true statement it would be impossible to expand Medicaid nursing home services without increasing the overall budgetary allocation. Last year the Health and Human Services Finance Commission, according to my information, spent all of the money given to them by the General Assembly for nursing home beds for the indigent in this state. Until such time as the General Assembly, the Finance Commission and the Department of Health and Environmental Control, in unison, approve new construction for Medicaid beds and new funding for Medicaid beds, no other mandated piece of legislation will solve the bed shortage. You can only buy those services and those amounts of services that the budgetary allocation will allow. Our population that needs these types of services is rapidly increasing.

Presentation to the Joint Legislative
Study Committee on Aging
by: J. Randal Lee, Executive Director
South Carolina Health Care Association

Page 2

For several years now there has been no increase in funding and there has been a moratorium on new Medicaid bed construction. This cannot continue if we are to meet the demands for these services and if we as citizens and legislators of this state are to provide those services which our elderly and other needy citizens rightfully deserve.

We have in the past year seen a great deal of state monies poured into our state prison system. Much of this has been caused by Federal court order. Surely we would never reach the point that the elderly of this state should be denied nursing home care, community long term care, meals on wheels, or any other services in order that criminals may receive more square footage in their cells.

TESTIMONY

Beverly W. Lomax, representing the Older American Volunteer Program Assoc.

The Older American Volunteer Programs consist of the Foster Grandparent Program, Senior Companion and Retired Senior Volunteer Programs. The Older American Volunteer Program Association consists of project directors and associates who meet together to discuss concerns and to exchange ideas for program enhancement. In the state of SC, there are twelve Older American Volunteer Programs.

I would like to share with you at this time a little information about each of the OAVP programs.

Foster Grandparent program. There are three FGP programs in SC serving Aiken, Barnwell, the Midlands, and the Low Country. Grandparents must be 60 years of age or older. They must meet income guidelines to qualify and are expected to work 20 hours a week with children who have special needs. The Grandparents receive a free physical annually, transportation or reimbursement for travel, free meals, insurance and a stipend of \$2.00 an hour. In SC our Grandparents are known for their work with retarded youth, but are now branching out to more community based services as with headstart, working with special children in the public schools, and with troubled teenagers. Currently 47 Foster Grandparents work through the SC Department of Mental Retardation and three are being placed with SC Department of Youth Services. Although these state agencies contribute support to the Grandparents in the form of meals, physicals, and some transportation, there is no doubt that the state receives a comparable amount in services, if not more. If the state had to pay minimum wage for the 88,520 hours these volunteers give each year, it would amount to \$279,790. Statewide there are 64 Foster Grandparents providing 161,008 hours of service annually.

The Senior Companion in Orangeburg and Calhoun counties operate similarly to the Foster Grandparents program in that volunteers receive a stipend. Instead of children, the Companions serve frail elderly citizens. Though we seem to hear so much now about providing services to prevent institutionalization, Companions have been working in the area of long term care since 1976. Companions serve in adult day care centers, with the majority of the Companions caring for 2 people daily in the client's home. Again keeping individuals out of institutions

as long as possible. Today there are 60 Companions, serving 62,400 hours annually.

The 8 Retired Senior Volunteer Programs serve 12 counties: York, Spartanburg, Charleston, Dorchester, Berkley, Colleton, Florence, McCormick, Newberry, Greenville, Richland and Lexington. Volunteers 60 years of age and older, are recruited to work in non-profit agencies. Volunteers are currently working in the crucial areas of literacy, in-home care, crime prevention, juvenile delinquency, nutrition and health care. Through the Retired Senior Volunteer Program, volunteers are assisted with travel and meal expenses. Insurance is provided for all volunteers. Again benefits are offered through the OAVP programs to help volunteers overcome barriers that may otherwise prevent them from volunteering. Through the Retired Senior Volunteer Program, 4066 volunteers serve annually, contributing 677,080 hours to local community needs.

Whether you are speaking of FGP, SCP or RSVP, we believe that our programs are effective in human terms as well as cost effective. Our volunteers live healthier, fuller lives because of the work they do. It is not unusual to hear a volunteer remark that their volunteer work gives them a purpose in life. Also through the services that our volunteer provide, individuals are able to remain in their homes and not be institutionalized. Let's say one-fifth of the older people served by Senior Companions are kept out of nursing homes and that 5 more are kept home because of RSVP volunteers, that's approximately \$432,000 saved if we used a modest figure of \$1200 a month per nursing home patient. And what about the value of the number of tutors joining the fight against illiteracy or the health education, fitness programs conducted by volunteers which contribute to preventive health measures? What about the knowledge and skills that these volunteers have to offer in technical and management assistance to our local non-profit agencies? Think about the social services the volunteers offer through local agencies that otherwise may have to turn citizens in need away. Consider how much richer we all are because of the interaction of old and young in some placements?

Though our number of volunteers continue to increase and the array of services provided to communities by volunteers greater, some of our progress is stifling for lack of local funds. All of the OAVP programs a provided a certain portion of funding through federal dollars from ACTION, with a requirement for local match. Some projects have lists of volunteers who need travel reimbursements in order to

serve, still other projects experience high staff turnover due to inadequate salaries and support staff. Efforts are hampered to expand to other areas such as to rural areas because of travel expenses. The last time our programs received an increase in OAVP funding was in 1980. Part of ACTION's increase in funding was to help start a new RSVP project in the state. Unfortunately, this project failed within the first year when no other sponsor could be found that could undertake the matching of the grant. The project was lost to Georgia.

In our Association, we are facing the same realities that other agencies are- we are expected to provide increased services with the same or less money. Private contributions and local dollars are being stretched to cover many areas. Gramm-Rudman and its affects are still lingering. We realize that we need to explore other options for additional funding for our projects. State funding is one possibility that comes to mind and may be approached in the future since there are some projects throughout the country that have state funds earmarked for OAVP projects. Georgia & Alabama being two such states. There are some projects that are funded totally by funds other than federal dollars from ACTION.

Again this may be an alternative we may pursue in the future since we feel strongly that by funding senior volunteers, there will be an impact on a number of social issues ranging from public education to long term care for the elderly, from child abuse to health education, from mental retardation to juvenile delinquency and many more. What distinguishes our programs from all the rest is that we view the older person as the service provider and, in turn, our communities benefit from the experience and time these volunteers give.

Thank you.

Vera L. Vincent
11 N. Clemson Townhouses
Clemson, SC 29631

STATEMENT OF THE SOUTH CAROLINA STATE LEGISLATIVE COMMITTEE
AMERICAN ASSOCIATION OF RETIRED PERSONS

before the
JOINT LEGISLATIVE STUDY COMMITTEE ON AGING
COLUMBIA, SOUTH CAROLINA

OCTOBER 1, 1986

Presented By
Vera Vincent, Chairman
South Carolina AARP State Legislative Committee

Thank you for this opportunity to appear before the Joint Legislative Study Committee on Aging. My name is Vera Vincent and I serve as the Chairman of the South Carolina State Legislative Committee for the American Association of Retired Persons (AARP). AARP has over 185,000 members in the state of South Carolina.

Earlier this year, the AARP South Carolina State Legislative Committee conducted a survey to determine legislative concerns of members of AARP chapters and AARP retired educators' units. As a result of the survey, the State Legislative Committee (SLC) has identified six major legislative objectives for 1987 which I would like to bring to your attention.

- o Restrain the rise of health care costs in South Carolina through publication of hospital rates, rate review procedures, and other appropriate means.
- o Delay institutionalization of frail elderly by establishing a statewide community services program to include such features as home health care, transportation, homemaker services, home-delivered meals, respite care, adult day-care and financial incentives.
- o Assure Medicare and Medicaid recipients access to health care services and facilities without discrimination.
- o Provide pre-admission screening for long-term care services and information on available community-based alternatives.
- o Provide an increase for retired state employees and teachers who have been retired the longest in making post-retirement benefit adjustments.
- o Increase the homestead exemption allowance for elderly home owners from \$20,000 to \$30,000.

It gives me much pleasure to point out that two priorities of the past few years, the revision of the Probate Code and the Death with Dignity Act, were passed by the legislature in the last session. We wish to express our appreciation to the members of this Joint Study Committee for introducing the legislation and for your interest and assistance in the passage of these bills.

Health Care Cost Containment

1. Our first priority, restraining the rise of health care costs, is of major concern to the elderly, and, in fact, to all South Carolinians. Last year the costs were held to a lower rate of increase than for the past several years. We feel that this was due to less inflation, of course, but also to some good legislation and to a nationwide demand of the citizens, led by twenty-two million AARP members, to hold down the costs. However, we are again seeing major increases in some areas.

The committee's first recommendation is that hospitals should be held to a target rate that is reasonably in line with the general inflation rate in our state. Our second recommendation is to develop a comprehensive health care data collection system that provides information useful to consumers and purchasers of health care. The cost, price, and quality data from a variety of health care providers should be collected. At a minimum, consumers need to have good information on price and quality for hospitals, physicians, and nursing homes. Our third recommendation is to develop a competitive health care system. The system must contain mechanisms for cost containment if competition fails.

We, the members of AARP in South Carolina, see cost containment as the single most important factor determining the quality of our health care.

Community-Based Long Term Care Services

2-4. Our priorities, 2 thru 4, relate to long term care. South Carolina has set up a state-wide program for Medicaid recipients. The program offers pre-admission screening for recipients and persons who could shortly become dependent upon Medicaid. Case management, various therapies, respite and adult day care, and other non-institutional services are also available. The state's program is comprehensive and an excellent use of Medicaid funding and Medicaid's home and community-based services waiver.

Unfortunately these services are not, for the most part, available to non-Medicaid recipients. The Association advocates making these services available to all elderly persons, on a sliding fee scale basis. A sliding fee scale would allow the elderly of all income levels access to a wide range of long term care services.

Quite often the frail elderly, even if they do have the resources to pay for their own care, do not know how to access the long term care system. In addition, they often do not know which services would be most useful. To reduce the difficulties in accessing long term care services, South Carolina should set up local points of entry into the system.

Our goal is to set up a state-wide long-term care program for all of the elderly. However, we recognize that we may have to begin with a pilot project in several counties. Such a project would enable the state to determine the best methods for extending long-term care services to the non-Medicaid population. A state appropriation of \$250,000 for the past two years has allowed for a beginning of this project.

The services that are most important to development of a good long-term care system for private paying clients are pre-admission screening, case management, and respite care services. Without proper screening and case management it is very difficult for the elderly to manage the services they need to remain at home. Respite care helps family care givers, who deliver 80% of long term care, to keep the frail elderly at home. We need to facilitate and support these efforts.

Post-Retirement Benefit Adjustments for Retired State Employees and Teachers

5. Another of the priorities for 1987 is to provide for an increase for the retired state employees and teachers who have been retired the longest in making post-retirement benefit adjustments. I know that other groups speaking here today will address this issue; therefore, I will not go into any detail in my testimony.

Homestead Exemption

6. The State Legislative Committee is very much concerned with increasing the homestead exemption allowance for elderly homeowners from \$20,000 to \$30,000. The reassessment of property and the levying of higher and higher property taxes have made the present homestead exemption most inadequate for elderly people. The AARP maintains that increasing the homestead exemption is the best means for delivering property tax relief to older citizens since the overwhelming majority of the elderly are on a fixed income. This is a very strong legislative priority of our constituents. We urge immediate passage of an appropriate bill.

Finally, I want to thank you for the Joint Study Committee's consideration of the elderly in South Carolina. We can collectively take great joy in the 1986 passage of amendments to the South Carolina Probate Code and the Death with Dignity legislation. We look forward to future cooperative efforts and successful consideration of legislative priorities which will be beneficial to South Carolina's older population.

HEALTH INSURANCE FOR SENIOR CITIZENS

A System With Developing Problems

As the cost of medical care continues to increase Health Insurance for Senior Citizens becomes of increasing concern to them, and I hope, to members of the Joint Legislative Study Committee on Aging.

Medicare provides the major coverage for many retired persons, it is a great comfort to many of us of average means to know we have it, but now it sometimes has nightmare aspects if one becomes ill and needs to use it.

Not only the amount Medicare pays for a medical procedure, but the speed with which it pays is important, as many Medicare-supplement policies do not pay anything until the supplement carrier receives a written report from Medicare on how much it paid along with the amount of the bill. And if Medicare normally waits one or more months to pay, and the care provider is waiting for his money from Medicare, you may be sure the provider adjusts charges accordingly.

Health insurance coverage, for senior citizens especially, is becoming increasingly complex, and filing claims and collecting on them is likely more difficult than you know if you are without first-hand experience. Add this to the fact that many people become more easily confused the older they grow, and you understand why many older persons who need the money and at least have Medicare, may never submit their medicare claim, or, if the slightest thing goes wrong, actually collect it.

This is why health care providers who actually fill out and file insurance claims for their older patients provide such a welcome and needed service.

I believe the health insurance system for senior citizens living in South Carolina should work better than it does, and that the segment of Blue Cross Blue Shield of South Carolina which administers the Medicare program in South Carolina bears considerable blame for this. I will first discuss my attempts to receive health insurance reimbursement for treatment provided me on Jan. 25 for this year.

I have late-onset asthma and about midnight on Jan. 25 began suddenly gasping for breath. I awoke my wife who took me to a 24-hour medical clinic nearby. I was incoherent from pain and inability to breathe and she answered the questions of the admitting nurse.

After an extended period of treatment by the physician I was able to breathe again and to return home, and the clinic said it would file with Medicare.

I did not hear from Medicare until April 25 when I received a standard "Explanation of Medicare Benefits" form stating that none of the \$133 itemized bill would be paid as I was not covered by Part B of Medicare.

I immediately called Medicare in Columbia to say they were mistaken. When I finally got through to a Medicare representative she quickly found my claim, and, after a brief conversation and re-checking, said my records showed that I do have Medicare Part B Coverage. She said she would make the proper notation and that the Medicare payment could be expected in four to six weeks.

I checked again with the medical clinic on July 2 and, upon finding that they still had not received payment I again called Medicare in Columbia. The representative listened politely, quickly located my record, and informed me that for some reason nothing had been done after my call in April. She promised, however, to make the necessary correction, and said she would do what she could to expedite payment.

At this time she explained that the reason the original claim had been denied on grounds that I did not have Part B of Medicare was because in some way my wife's Social Security number had been listed as mine on the initial claim. As my wife is not yet 60 and does not yet have either Part A or Part B of Medicare coverage I wondered about this, but I was so glad to be told that the mistake had been corrected that I did not ask about that matter.

Sure enough on July 20 I received a small Medicare payment, but the Jan. 25 bill had been altered until it was almost unrecognizable. The original Medicare form had at least correctly shown the original amount billed as \$113 with the correct subtotals also in place. The new Medicare form showed completely new subtotals under the "Amount Billed" column and the total of this column was just \$31. The form showed Medicare was sending me \$24.92. The difference between what Medicare was paying and the apparent total bill was \$6.08.

Again I called Columbia, "If I submit this form to the Medicare-supplement carrier the most it will pay is \$6.08 and I'll be left owing the clinic \$82," I said. How can Medicare change figures like that?

Well the Medicare representative had an answer. It was the fault of the Medicare computer, whose limited capacity makes it necessary to use the "Amount Billed" column on any resubmitted Medicare claims to list not the amount billed but the amount Medicare will approve for the particular medical treatment provided, she explained. I have been told that Blue Cross Blue Shield's Medicare computer is the largest computer in South Carolina, but maybe it's still just not large enough.

This Medicare representative did try to be helpful. She said if the record had shown that my Jan. 25th treatment had been received at midnight when practically all doctors' offices are closed a larger amount would have been approved by Medicare. So I had this confirmed by the clinic doctor. But I wasn't benefitted. Some of you may have guessed that three weeks later I was informed the entire claim was being denied as I don't have Medicare Part B.

Let me mention another Medicare claim briefly. In late April at 1 a.m. I had an even worse asthma attack. This time as soon as the clinic physician checked my pulse he said I must be taken to the emergency room of the hospital immediately as my heart beat was irregular.

The ambulance charged \$133.48 and Medicare paid \$50.22 of the total. On one \$15 charge -- for providing heart monitoring on the way to the emergency room I believe, Medicare paid 10 cents. Was the amount billed nearly 1,000% above the average charge for heart monitoring? Was this Medicare's way of saying I didn't need that service?

Yes I've called Medicare numerous times about my problems and written them, too. It seems to me that if they provide you with a toll-free number the implication is that many problems can be straightened out with a simple phone call, but I have not found this to be so. When I get completely exasperated and use my own money to call, asking to speak to the person in charge she is never in, and she never bothers to return my call either.

This year several times I've received a communication from Medicare in Columbia that it is actions in Washington which have resulted in Columbia's slowdown in processing claims, and I have concluded that the "Big Chiefs" in the the Columbia Blue Cross Blue Shield Medicare office have used this as an excuse to ignore virtually all complaints.

I do know that in August when I had blood tests and x-rays done in the hospital in Bryson City, N.C., Medicare of North Carolina processed the bill for \$74.15 and paid \$65.48 in less than 20 days from the time the tests were performed.

Recently I met with a group of Greenville senior citizens and found that a large number of them have been experiencing problems with Medicare claims.

I believe there are genuine, and serious problems with the way South Carolina's Medicare program is being administered. Incidentally I have documents to substantiate what I've told you concerning my recent experiences.

It's a different matter, but I'm told by some physicians who have moved here from other states that the amount paid by Medicare in South Carolina for many medical procedures is far less than in many other states. Are there good reasons for this or is it mainly politics?

I think these things deserve your immediate attention and I hope they will receive your attention. Medicare, I believe, should provide a significant part of the total payment for needed medical care of senior citizens. An efficient Medicare administration here and the insistence by state legislators that Medicare pay approximately the same percentage of standardized medical services here as in any other state are both prerequisites for a first rate health insurance system for Senior Citizens in South Carolina.

I am Frank McCraw I have been retired for seventeen years and if I live to be one hundred I have another seventeen years to go. There has been many changes so I do all I can to keep informed, and try to inform my fellow man where it is possible.

I wish to thank the South Carolina Legislators for passing the Probate Code and Death With Dignity Laws. I trust they will be used in the proper manner. I was talking with A Doctor some time ago about the death With Dignity bill and he was opposed to the bill saying that the last years of life are when A doctor gets the grater amount of money.

When Social Security was passed it was to take the older person out of the work force to make work for the younger person. with sixty Five set as the retirement time, how- ever there has been constant changes in payment to retirees, in deductions from ^{Earnings} ~~payments~~ and retirement age. With other retirement plans now available perhaps we should look at these facts when placing additional requirements on our State Government.

Lottery is another way to say to our people that other States are doing it so we should do that too. Two wrongs do not make A right. We should look at what is wright and wrong and do what is wright so every one will benefit.

One of my interest today is the medication useage. I do not take medication and I am very thankful that I do not have too, but I do keep informed of this item and note that advertisers promote more by illustrating two tablets, constantly speak of more is better, also say stronger is better. This has caused many people to find themselves in serious trouble. Many over the counter medications should not be taken with some subscription medications. All medications have some side effects. The most prosperous industry today is the Pharmacutal industry. I was in A drug store recently to pick up A subscription for another party and A woman was there to pick up A prescription, when the druggest said it would be ninety dollars, she said she would have to sit down to write a check for that much.

Because I am elegible for medicare and have A supplemental policy does not mean that health care does not cost me anything. I do pay insurance on both policys.

Many older people have trouble deciding oh how much health insurance to buy or which policys to buy. It is posible to buy policys that do not pay if another police pays and when the person finds this out is probably when they have A claim. The insurance agent is supposed to alert you to this fact but they do not all do that.

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William K. James, Commissioner

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Statement to: Joint Legislative Study Committee on Aging

From: William K. James, Commissioner

Date: October 1, 1986

Chairman Harris and members of the Committee, I thank you for the opportunity to make this presentation on behalf of the elderly blind in South Carolina.

Last year at this time, there was no Independent Living Program for the Elderly Blind. Those persons who are over 65 and who are blind, but could not function independently had no hope except for the very few who are eligible for Vocational Rehabilitation services. They had no expectation of being able to continue to live in their own homes. Their only alternative was to move in with family members, go to a nursing home, or other institution.

On July 1, 1985, things started to change, thanks to you and other concerned legislators. South Carolina Commission for the Blind was given an appropriation of \$75,000 to start an Outreach Program for the Elderly Blind. The purpose of this program was to teach the basic skills to elderly blind persons to enable them to live independently in their own homes; thus, avoiding the need for institutionalization. The skills that they would learn are those that sighted people take for granted such as the ability to travel independently, learn how to perform activities of daily living, simple homemaking skills, and communication skills to enable these persons to have direction and purpose for their own lives.

As you are aware, funds for new programs were frozen for last year until January 1, 1986. We have had to recruit and train staff in gerontology and

Statement to JLSCA

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October 1, 1986

are very proud of what we have been able to accomplish in such a short period of time. We have provided services for 47 elderly blind persons. Sixteen have been trained in our Outreach Program. These persons are brought into churches or community centers and trained in small groups of 8 to 12. They are taught how to use aging appliances and given instructions in functioning as a blind person. We have also worked with other agencies and institutions to provide instructions for their staff in how to work with blind persons. In June of this year, we had 50 referrals on our waiting list.

Again, thanks to you and other concerned legislators, we were given an additional \$50,000 on July 1 of this year to expand the program. We now have 3 teams consisting of a Mobility Instructor and Rehabilitation Teacher working out of the Greenville, Columbia, and Charleston Offices. They are working in the rural areas and are getting into the clients' homes in order to help them mark their stoves and appliances, and meet the specific needs that these persons have.

There are over 8,000 blind persons in this State and half of them are 65 and older. It is apparent, therefore, that we are just starting to meet the most glaring needs. By employing teacher's aides, we will be able to work with larger groups and provide more services. We will also be able to purchase low vision aids, white canes, braille clocks, timers, and other aids and appliances that blind persons use. We believe that we will be able to double the number of persons being served in this program with this additional funding. This will obviously result in savings to taxpayers if we can prevent these persons from having to be institutionalized, and who can place a price tag on just being able to live in your own home, if that's your desire.

Yesterday, we received a telegram stating that we would be receiving an appropriation of \$200,000 from the Federal Government to serve 120 additional older blind persons. This was a result of a proposal that was submitted a few months ago.

Statement to JLSCA

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October 1, 1986

With these additional funds, we plan to bring 18 persons to the Rehabilitation Center here in Columbia, where they will receive training up to eight weeks. We will now have funds to pay for this, plus their transportation, purchase aids and appliances, physical therapy, occupational therapy, and other rehabilitation services. In addition, we expect to enroll 36 more persons in our mobile outreach units throughout the State. We estimate that 20 persons will receive low vision evaluations and aids to enable them to utilize to the maximum their remaining vision. These funds will also enable us to provide additional case work and prevention of blindness services.

This program will be funded for one year. There is no assurance that it will be continued ^{that} past/time. Obviously, we will try to have the program extended, but we must compete with other states as we did to obtain the initial grant.

As a part of a request for this funding, we explained that \$75,000 had been appropriated to start this program, and that we had requested an additional \$50,000 to make sure it would be continued and expanded.

The possibility of continuing the program if the Federal Government did not participate past the first year was rated very heavily on the evaluation. It is my firm conviction that you and your support of this state-funded program has enabled us to obtain an additional \$200,000 in federal money. The most important thing, of course, is the fact that older blind persons will live richer and fuller lives, and will be able to maintain their dignity and independence and continue living in their own homes.

The only thing that we are asking on behalf of these deserving citizens is that you accept our sincere appreciation and gratitude.

- Rep. Harris - Bill, how are your interstate stores coming along?
- James - Beautifully. In fact, in the past 2 years we have built 20 of these locations along the interstate highways. We are estimating those locations are bringing in about 1 million dollars in tourist money each year. Certainly we welcome that. More importantly it is providing good employment opportunities for blind persons. Every time we put in one of these locations it costs us about \$25,000 to do it. And we get our returns within a year on that investment. The important thing is putting people to work and taking them off the tax rolls and its a tremendous program. I think it demonstrates to the public that South Carolina is concerned about their handicapped citizens so it is really cost effective and beneficial for everyone.
- Sen. McLeod - On the same line, when we did that I was under the impression, maybe I was misinformed, but I thought the profits from those were going to go to the Commission for the Blind. I understand that this is not the case. They go to the individual vendor. And further, I understood they were making \$80,000 a year.
- James - That sounds awfully high, Senator. I don't know the figures. The money does not go to the Commission. These people earn whatever profit they have. Now keep in mind these vendors are responsible for being there 7 days a week to keep these operations going. Now some do very well, again \$80,000 is very high.
- Rep. Harris - It's kind of like a franchise.
- James - That is a very good way to put it.
- McLeod - My understanding, Mr. Chairman, that's what I'm trying to ask. I understood it was not like a franchise deal. My impression when we passed it was the Commission for the Blind was really going to be the main beneficiary of it and that the Commission for the Blind builds the thing, they give it to the vendor and the Commission doesn't get anything back out of it.
- James - That's partly true. The Commission is still the main beneficiary because we are providing good employment opportunities for blind people and that is our main purpose. Right now we build locations, we retain title to those locations. The vendor is responsible for stocking the machines, making sure they are kept working properly. But the profit from those machines goes to the vendor not back to the Commission.

- Sen. McLeod - And they don't pay any maintenance on the station that we built.
- James - The Commission does not receive any money back from these locations. There was a law passed 10 years ago that the vendors themselves would not pay money back to the state for the privilege of operating these locations. At that time there weren't any on interstate highways. That's only been done in the past two years but we have 95 of these locations throughout the state, 20 on interstates. The average income is somewhere between \$19,000. They are good opportunities for blind persons to earn a living. The pay back as far as we are concerned, is we can get people off of the tax roll and we don't have to supplement their income. That is really good payback. On an average money invested in rehabilitation programs, the returns are about \$11 for every \$1 invested.
- Sen. McLeod - Let me suggest that the Commission look into the matter. Because if you have some individual locations that are earning as much as \$80,000 a year which the state has spent the money on building the station and all the facilities and there's no rent paid, there's nothing else, there are a lot of other blind people in the state that could use the benefit of some of that profit.
- James - I will certainly check into that. And again I could assure you that no blind person in the state is making \$80,000 a year running a vending stand. Your point is well taken and if these people are making above the point that the taxpayers should be subsidizing, I agree with you sir, we should not continue to do that.

At this time Dr. Parrish made the following request.

Dr. Parrish - There is another imperative that I as a member of this Committee have a deep concern about which has to do with the high costs of health care, I request that this concern be placed on our agenda for the next meeting wherein we would look at the insurance law as it pertains to the administration of health care and that the SCFOA be involved in the educational process so that we can come to understand the A B and C programs. I ask to be presented on the agenda of our next meeting this month.

James LeBlanc
835 Gregg St.
Columbia, SC 29201

Mr. LeBlanc submitted for the record two documents which follow, "Death with Dignity Act," and "The Problems Presented by Death with Dignity Act."

Mr. LeBlanc suggested the involvement of other interested persons such as the S.C. Bar

Senator Doar and Senator McLeod suggested that Jim LeBlanc work with Keller to develop whatever amendments are needed and present to the Committee so they can be introduced.

Death With Dignity Act

The South Carolina Death With Dignity Act¹ By James L. LeBlanc²

Governor Richard W. Riley recently signed into law the long awaited Death With Dignity Act,³ the legislation lending statutory support to the validity of the so called Living Will. In a preamble and seventeen sections, the Act sets out legislative findings supporting enactment of the statute, defines the substance and sets forth the form of the Declaration Of A Desire For A Natural Death,⁴ and states the legal effect to be given to the Declaration.

A. Form of the Declaration

Section 5 of the Act provides the form of the Declaration, requiring that to be given the effect intended by the statute a Declaration be substantially in the following form:

State of South Carolina
County of _____ Declaration of a Desire
For A Natural Death

I, _____, a resident of and
domiciled in the City of _____,
County of _____, State of South Carolina,
make this Declaration this _____ day of _____, 19____.

I wilfully and voluntarily make known my desire⁵ that no life-sustaining procedures⁶ be used to prolong my dying if my condition is terminal,⁷ and I do hereby declare:

If at any time I have an incurable injury, disease, or illness certified to be a terminal condition by two physicians⁸ who have personally examined me, one of whom is my attending physician,⁹ and the physicians have determined that my death will occur without the use of life-sustaining procedures and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

In the absence of my ability to give directions¹¹ regarding the use of such life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians as the final expression of my legal right¹² to refuse medical or surgical treatment and I accept the consequences from such refusal.

I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures.¹³ I am emotionally and mentally competent to make this Declaration.

THIS DECLARATION MAY BE REVOKED¹⁴ BY THE DECLARANT,¹⁵ WITHOUT REGARD TO HIS PHYSICAL OR MENTAL CONDITION:

1. BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED BY THE DECLARANT OR BY SOME PERSON IN THE PRESENCE OF AND BY THE DIRECTION OF THE DECLARANT.

2. BY A WRITTEN REVOCATION SIGNED AND DATED BY THE DECLARANT EXPRESSING HIS OR HER INTENT TO REVOKE. THE REVOCATION SHALL BECOME EFFECTIVE ONLY UPON COMMUNICATION TO THE ATTENDING PHYSICIAN BY THE DECLARANT OR BY A PERSON ACTING ON BEHALF OF THE DECLARANT. THE ATTENDING PHYSICIAN SHALL RECORD IN THE PATIENT'S MEDICAL RECORD THE TIME AND DATE WHEN HE RECEIVED NOTIFICATION OF THE WRITTEN REVOCATION.

3. BY A VERBAL EXPRESSION BY THE DECLARANT OF HIS INTENT TO REVOKE THE DECLARATION. THE REVOCATION SHALL BECOME EFFECTIVE ONLY UPON COMMUNICATION TO THE ATTENDING PHYSICIAN BY THE DECLARANT. THE ATTENDING PHYSICIAN SHALL RECORD IN THE PATIENT'S MEDICAL RECORD THE TIME,

DATE, AND PLACE OF THE REVOCATION AND THE TIME, DATE, AND PLACE, IF DIFFERENT, OF WHEN HE RECEIVED NOTIFICATION OF THE REVOCATION.¹⁶

Declarant

STATE OF SOUTH CAROLINA
COUNTY OF _____

AFFIDAVIT

We, _____, the witnesses¹⁸ whose names are signed to the foregoing Declaration, dated the _____ day of _____, 19____, being first duly sworn, do hereby declare to the undersigned authority¹⁹ that the Declaration was on that date signed by the said declarant as and for his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence²⁰ and we, at his request and in his presence,²¹ and in the presence of each other,²² did thereunto subscribe our names as witnesses on that date. The declarant is personally known to us and we believe him to be of sound mind. None of us is disqualified as a witness to this Declaration by any provision of the South Carolina Death With Dignity Act.²³ None of us is related to the declarant by blood or marriage; nor directly financially responsible for the declarant's medical care; nor entitled to any portion of the declarant's estate upon his decease, whether under any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the declarant; nor the declarant's attending physician; nor an employee of such attending physician; nor a person who has a claim against the declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the declarant is a patient. If the declarant is a patient in a hospital or skilled or intermediate care nursing facility at the date of execution of this Declaration at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.²⁴

Witness

Witness

Witness

Subscribed, sworn to and acknowledged before me by _____,
the declarant, and subscribed and sworn to before me by _____,
and _____, the witnesses, this _____ day of _____, 19____.

(SEAL)

Notary Public

My Commission Expires: _____

B. Execution of the Declaration

Evidently, the Act sets forth considerably complex requirements to achieve due execution of such Declarations. There follows a suggested form letter of instructions for the due execution of a Declaration, drafted for submission to a client along with a form of Declaration. It could as well serve as a checklist for an attorney supervising the execution of a Declaration.

"In order properly to execute the Declaration and the attached Affidavit and Acknowledgement, gather into your presence three witnesses and a Notary Public, not including your spouse, not including anyone related to you by blood or marriage, and not including your attending physician and any employee of any such physician. None of the three witnesses may be a person who is financially responsible for your medical care, or who is an expectant beneficiary of your estate, or who is a beneficiary of your life insurance, or who is or would be a claimant against your estate should you die at this time. If you are a patient in a hospital or nursing facility, a health facility, at the time of the execution of the Declaration, then no more than one (preferably none) of the three witnesses may be an employee of that facility, and, additionally, at least one of the three witnesses must be an ombudsman designated by the State Ombudsman in the Office of the Governor.

"In the presence of the three witnesses and the Notary Public, you should state that you willingly make the Declaration, and then complete the top portion of the first page of the document, the

Declaration, filling in the name of the County in which the signing is taking place, and the date, month and year of the signing, and then sign the first page at the signature line provided for the Declarant at the bottom of that page. The witnesses and the Notary Public should observe all of this, all present in the room at the same time.

"Next, turn to the second page of the document, the Affidavit, and complete its top portion, filling in the name of the County in which the signing is taking place, the names of the three witnesses, and the date, month and year of the signing. Read the text of the Affidavit out loud to the three witnesses, ask them whether its contents are true, and, on their assent, then request that they sign the second page at the signature lines provided for the Witnesses near the bottom of that page.

"Next, complete the bottom portion of the second page, filling in the names of the three witnesses, and the date, month and year of the acknowledgement of the signing of the Declaration (usually the same as the signing itself). The Notary Public will then take your acknowledgements and oaths and supply his signature, his commission expiration date, and his seal."

C. Legal Effect of the Declaration

The legal effect to be given to such a Declaration is set forth in various sections of the Act. Most generally, under the defined circumstances, the Declaration of an adult will serve to allow the withholding or withdrawing of life-sustaining procedures,²¹ without constituting suicide,²² but only after at least six hours of active treatment,²³ and not at all if the patient is pregnant.²⁴

Not only are the patient's own wishes thus respected, but, further, the position of the physician asked to act on the Declaration is protected. The physician is presumed to have acted in good faith in withholding or withdrawing life-sustaining procedures and he is given immunity as to civil and criminal liability, unless it is shown that his actions violated the standard of reasonable professional care and judgment under the circumstances.²⁵ Conversely, the physician who fails to effectuate a Declaration in appropriate circumstances and who fails or refuses to transfer the patient to another physician prepared to effectuate the Declaration is said to be guilty of unprofessional conduct.²⁶

The Act provides several protections against the misuse of such Declarations. No person may be coerced into signing such a Declaration in order to obtain insurance, medical treatment or admission to a hospital or nursing home.²⁷ Persons other than the Declarant who coerce or fraudulently induce the execution of a Declaration or who knowingly provide false information relative to a Declaration are subject to civil damages,²⁸ and criminal penalties.²⁹ No affirmative or deliberate act or omission to end life, other than to permit the natural process of dying, is excused or allowed by the Act.³⁰

The Act even covers the case in which no Declaration has been executed, stating that in that case no presumption arises as to the patient's intention to consent to or to refuse "death prolonging procedures."³¹

1. Death With Dignity Act (R360, H2041, effective 3/6/86), _____ S. C. Acts & Joint Resolutions _____ (1986).

2. The author is an attorney in private practice in Columbia. Formerly an Associate Professor of Law at the University of South Carolina School of Law, teaching trusts and estates and probate law, he has also been Reporter of the proposed South Carolina Probate Code.

3. Thus to be cited, §1. The Governor signed the legislation on March 6, 1986, the effective date of the statute, §15.

4. This is the cumbersome but descriptive label given to the document by the Act, §5, much to be preferred to the vague and ambiguous term "living will."

5. The date is required, §4.

6. Required by §4.1.

7. "Life-sustaining procedures" is defined as procedures "which would serve only to prolong the dying process ... where, in the judgment of the attending physician, death will occur whether or not (sic) such procedures are utilized ... [not including] the administration of medication ... [nor] treatment, nutrition, and hydration for comfort care or alleviation of pain." §2.b. "Compare the March 15, 1986 Statement of the Council on Ethical and Judicial Affairs of the American Medical Association, 'For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit [life prolonging medical] treatment to permit a terminally ill patient whose death is imminent to die ... Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life prolonging medical treatment. Life prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration.'"

8. "Terminal condition" is defined as existing when "to a reasonable degree of medical certainty (i) there can be no recovery, and (ii) death is imminent without the use of life-sustaining procedures." §2.d.

9. "Physician" is defined as any person licensed to practice medicine in South Carolina. §2.c.

10. The other is required to be a physician other than an attending physician. §3.

11. The Act's preamble reveals the purpose of the statute, "in order that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves."

12. The Act's preamble states the legislative finding that "adult persons have the fundamental right to control the decision relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition."

13. Required by §4.2.

14. See §6.

15. "Declarant" is defined as the signatory of such a Declaration. §2.a. The Act's title and its preamble contain references to "an adult," as does §3.

16. Required by §5, last paragraph, which states that the methods of revocation must be set forth in bold-face print.

17. Required by §4. The last paragraph of §5 requires that the Declarant's signing be done in the presence of the three witnesses.

18. Required by §4.3.

19. Required by §5, last paragraph.

20. See §5, last paragraph.

21. See §5, last paragraph.

22. See §5, last paragraph.

23. Required by §5B.

24. Required by §§4.1, 5A, and 5B.

25. §1.

26. §9.

27. §1. "Active treatment" is defined as "the standard of reasonable professional care that would be rendered by a physician to a patient in the absence of any terminal condition including but not limited to hospitalization and medication." §2.a.

28. §5B.

29. §7.

30. §4.

31. §10.

32. §13B1.

33. §§13A1 and 14.

34. §11 expressly denies approval to "mercy killing."

35. §12.

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The Problems Presented by Death With Dignity Act¹

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The following is the first of a two part series. The article will conclude in next month's Transcript.

A. Incorrect Forms and Improper Execution

The recently enacted Death With Dignity Act lends statutory support to the validity of the Declaration Of A Desire For A Natural Death, the so called Living Will. The statute's support is lacking, however, in cases of Declarations not substantially in the form set out in the Act and as to Declarations in the appropriate form but not executed in accordance with the requirements imposed by the Act. Further, the Act does not provide a mechanism external to the form of the Declaration itself for the proof of the valid execution of the Declaration. Rather, it is anticipated that the form and the method of execution offered by the statute will be self-validating, if used appropriately, but that mistakes will lead to litigation. Accordingly, it is of ultimate importance that in drafting Declarations and in supervising the execution of Declarations attorneys pay close attention to the form and to the method of execution required by the Act.

There is a very real possibility that our State's residents will be misled into executing Declarations in form or in method of execution not in conformity with the Act. Already *The State* newspaper has published a form of Declaration diverging in very substantial respects from the form required by the Act, with the statement, however, that, "[t]his is a suggested copy of the living will that is included in the law."³ Our Executive Director's letter to the editor correcting the error notwithstanding,⁴ no doubt some citizen, perhaps some attorney, has been led to use the newspaper's form.

The Society for the Right to Die has published and has widely distributed in South Carolina a printed form of Declaration, which is printed on the front and back of one page and is very handy for immediate execution by one wishing to make a Declaration. Unfortunately, the Society's form lacks some of the wording required by the Act to be included in the witnesses' Affidavit, while suggesting, in the form itself and in its accompanying cover letter, that the Declarant add "[o]ther directions" to the Declaration, such as instructions as to particular treatments to be withheld or withdrawn, e.g., "antibiotics, artificial feeding," and also suggesting the designation of a "proxy — someone you trust to make the treatment decision you would make if you were able."⁵

The Act sets forth considerably complex requirements to achieve due execution of Declarations. Briefly, the Act contemplates the knowing, voluntary involvement of the declarant, of three witnesses and of a Notary Public, with respect to the Declaration, an Affidavit and an Acknowledgement. The avoidance of the selection of witnesses disqualified to act is itself a very cumbersome matter. The most careful attorney will be embarrassed by the ritual required by the Act. Declarants not represented by attorneys are unlikely to have the awareness of and patience with the ritual required to satisfy the Act.

A Declaration not substantially in the form offered by the Act or one not executed properly exposes the person who signs it to the risk that it will not be given the effect intended. At the least, creative drafting and casual execution will invite a contest of the validity of the Declaration, with, perhaps, the consequence being the trial level and appellate litigation

sought to be avoided by the enactment of the Death With Dignity Act. For a correct copy of the form of Declaration offered by the Act and a suggested method of execution thought to be proper, see the April, 1986 issue of *The Transcript*.⁶

B. Defects in the Act's Own Form of Declaration

While the Act's form of Declaration is blessed with legislative sanction,⁷ it is in need of some revision in order to become a comfortable mechanism with which to formalize the typical declarant's intentions. The following suggestions, however, should not be taken as recommendations for incorporation into the Declarations drafted for execution by individual clients. While some of them might inoffensively be used now, they are offered merely to point up the problems faced by those who would now use the Act's form and in anticipation that they will be proposed for consideration in the legislative revision of the Act's form.

For brevity and clarity, and the better understanding of those asked to sign such Declarations, the order of presentation of the information in the Declaration should be revised. The present paragraphs 1 through 6, the numbering being the author's and not actually appearing in the Act's form, with paragraph 6 referring to the whole of the matter outlining the methods of revocation of the Declaration, should be re-arranged in the following order: paragraphs 1, 5 and 2 combined; 4, 3 and 6. This revision would group the contents of the Declaration so that the order of coverage would be: 1: name, domicile, and date; 5 and 2: awareness and capacity of the declarant combined with a voluntary expression of the desire to avoid life-sustaining procedures; 4: an expression of understanding that the Declaration takes

effect when the declarant is unable to give directions, 3: the actual directions to take effect in the event of the declarant's inability to give directions; and 6: the methods of revocation of the Declaration.

The Act's form was included in the legislation to provide readily available, inexpensive and fully reliable guidance to persons desiring to make Declarations. To that end, the form could be improved by clearly stating that only adults may sign such Declarations.⁸ That information should be included in paragraph 1 of the Declaration, with the declarant's name and domicile. Also, the Act's form should be revised, in its paragraph 3, to reflect that, of the two physicians required to certify to the declarant's terminal condition in order for the Declaration to take effect, one is required to be an attending physician and one is required to be other than an attending physician.⁹

The Act's form, in its paragraph 6, sets forth the entirety of Section 6 of the Act, as is required by the Act.¹⁰ The Act requires that this matter appear in bold-face print in the Declaration. While the Act itself shows this matter in all upper case letters, the Act does not expressly require that Declarations use that device and, in fact, the Act's form uses the upper case presentation as a code for bold-face print. The form offered by the Society For The Right To Die prints this matter in bold-face, lower case and small print. This last may satisfy the Act, but the very careful attorney will produce forms of Declaration with this matter in bold-face, upper case print of the same size as the print used in the rest of the Declaration. Revision of the statute should take this uncertainty of form into account.

The Act's form of Affidavit, prepared for execution by the witnesses, states several facts which might be stumbling blocks for the very cautious witness asked to swear to their truth. These statements should be corrected in any revision of the Act's form accomplished by further legislation.

First, the Affidavit¹¹ refers to "the witnesses whose names are signed to the foregoing Declaration" and avers that they "did thereunto subscribe our names as witnesses on that date." But, the Act's form of Declaration does not provide blanks for the three witnesses' signatures. Nor does it seem necessary or comfortable to require that the three witnesses actually sign the Declaration when in any case they will sign the Affidavit. Instead, the Affidavit should be revised to refer to "the undersigned witnesses to the foregoing Declaration" and to the fact that they "*do hereunto subscribe our names as witnesses on that date,*" adding the italicized language.

Second, to take into account the individual witness's inability to swear to the truth of the other witnesses' conditions and perceptions, and the witnesses' unavoidable reliance on information and belief, the Affidavit should be revised to state that the witnesses "*do hereby singly and severally declare to the undersigned authority, on the basis of our best information and belief, that*"

Third, the Affidavit states that none of the witnesses is disqualified by any provision of the Act and then goes on to list the various points of disqualification. A witness might be reluctant to swear to meeting the requirements of an Act that he has not read. The Act's form should be revised to state that, "[n]one of us is disqualified as a witness to this Declaration by any provision of the South Carolina Death With Dignity Act, *which we are informed contains provisions for the disqualification of witnesses as follows.*" There would then follow the Affidavit's listing of various points of disqualification.

While the Act's form contains a form of Acknowledgement¹² that states that the papers are "[s]ubscribed, sworn to and acknowledged" before the Notary Public, it would seem that the declarant has no occasion to swear to anything and that he would meaningfully acknowledge his signature to the Notary Public only if

he had subscribed his signature out of the presence of the Notary Public. It is not at all clear that the Act allows subscription out of the presence of the Notary Public with later acknowledgement before the Notary Public as a proper method of execution.¹³ If not, then, perhaps, the Act's form ought to be revised to state simply that the papers are "[s]ubscribed" by the declarant before the Notary Public.

C. Uncertainties as to the Method of Execution

The suggested form letter of instructions for the due execution of a Declaration, serviceable as a checklist for an attorney supervising the execution of a Declaration, included in the April, 1986 issue of *The Transcript*,¹⁴ reflects the following as requisites to due execution of a Declaration. There are questions whether the following is sufficient; the questions are raised in the parentheses.

As to the Declaration and the declarant, he should state a willingness to make the Declaration (but, to be very careful, should he read out loud the contents of the Declaration, perhaps not including the matter on methods of revocation?); he should personally date the Declaration (and fill in his name and domicile if those blanks have not already been completed by the draftsman, as well they might have been); he should then sign the Declaration; and all of the declarant's acts should be observed by all three of the witnesses and by the Notary Public.

As to the Affidavit, its blanks must be completed, acceptably by the draftsman or by any other person; the Affidavit should be read out loud to the three witnesses so that they are fully aware of what they are expected to swear to; the witnesses ought to be asked and ought to answer out loud that they do so swear; then the witnesses must sign the Affidavit each in their turn; and all of the witnesses' acts should be observed by the declarant and by the Notary Public.

As to the Acknowledgement, its blanks must be completed, acceptably by the draftsman or

by any other person; the Notary Public must have seen the declarant subscribe his name to the Declaration (and must take the oath and acknowledgement, just to be safe until the Act's form is revised); the Notary Public must have seen the three witnesses subscribe their names to the Affidavit and must take their oaths; the Notary Public is then to supply his signature, his commission expiration date and his seal.

The large question concerning due execution of a Declaration is whether and to what extent any parts of the ritual may take place out of the presence of the full complement of the declarant, the three witnesses and the Notary Public. Of course, if possible, the whole ritual ought to be accomplished in the presence of the whole group, collected together in one room at one time, with no one else present, excepting, of course, the attorney supervising the execution. But, exigent circumstances will, no doubt, arise in particular cases and require an answer to the large question. The Act states that,

"[t]he declaration must be signed by the declarant in the presence of three witnesses and shall be attested and subscribed in the presence of the declarant and of each other by the three witnesses and an officer authorized to administer oaths under the laws of the State where acknowledgement occurs or else the declaration shall be utterly void and of no effect."¹⁵

This would seem to require at the least that the declarant's signing take place in the presence of the witnesses and that the witnesses' attesting and subscribing take place not only in the presence of the declarant and of the other witnesses but also in the presence of the Notary Public.

Further, perhaps, the declarant must also sign the Declaration not only in the presence of the witnesses but also in the presence of the Notary Public. Lastly, perhaps, the Notary Public must also "attest and subscribe" the papers in the presence of both the declarant and the witnesses.

The Act's form provides its only signature lines for the witnesses following their form of Affidavit.¹⁶ Perhaps this may be taken as an indication that the witnesses are to attest and subscribe, as well as be sworn, in the presence of the Notary Public. Confirmation might be found in the form of Acknowledgement which states that the papers are "subscribed and sworn to before ... [the Notary Public] by [the witnesses]."¹⁷

If the witnesses are to attest, i.e. witness, as well as subscribe and be sworn in the presence of the Notary Public, as argued above, then perforce the Notary Public must be present when the declarant signs the Declaration because, of course, it is at that time that the witnesses witness the signing.

If all of the acts of the declarant and of the three witnesses are to take place in the presence of the Notary Public, then, perhaps, notwithstanding the departure from normal practice, the Notary Public could be said to "attest and subscribe" the papers when he signs the Acknowledgement. The Notary Public is not usually thought of as being an actual witness to the execution of the paper itself.

The conclusions to be drawn from this discussion of the ritual of execution of a Declaration are, first, that the cautious attorney will require that the whole ritual be accomplished in the presence of the declarant, the three witnesses and the Notary Public, and, second, that the Act needs revision to clarify the ritual requirements.

Another question exists as to the proper function of the State's Ombudsman acting as a witness in those cases singled out by the Act.¹⁸ The Act states that the legislative intent supporting the requirement is to provide "special assurance that [such patients] ... are capable of wilfully and voluntarily executing a directive."¹⁹ Attorneys should anticipate that the Ombudsman will take on an active role in the execution of the Declaration, inquiring of the declarant and, perhaps, of others aware of the

declarant's condition as to the declarant's capacity and freedom from undue influence. However, the Ombudsman has no mandate within the Death With Dignity Act to go beyond those concerns and to explore, for instance, the substance of the declarant's decision to forego life-sustaining procedures or the effect of the declarant's signing of the Declaration. In those further matters the Ombudsman will involve himself as a volunteer.

D. Legal Effect of the Declaration

A broad statement of the legal effect of a Declaration was published in the April, 1986 issue of *The Transcript*.²⁰ Very briefly, where an adult²¹ has duly executed a Declaration, unrevoked by her, where she is then found to be in a "terminal condition,"²² but not pregnant,²³ and where she has been given at least six hours of "active treatment,"²⁴ then "life-sustaining procedures"²⁵ may be withheld or withdrawn.²⁶ Where no Declaration has been executed the Act provides that no presumption arises as to the patient's intention to consent to or to refuse "death prolonging procedures."²⁷

E. Doubts as to the Legal Effect of the Declaration

1. The Text of the Act

One result of the stormy passage of the Act through the legislative process is that the text of the Act is rather poorly organized. To eke out the legal effect of a duly executed Declaration from a reading of the Act is itself quite a task. Reference is required to Sections 3, 5B, 7, 8, 9, 10, 11, 12, 13A, 13B and 14 of the Act, but most definitely not in that numerical order. Any revision of the Act should effect a clarifying re-ordering of the Act's contents.

2. Effectiveness of the Declaration

Several aspects of the Act's statement of the legal effect of a Declaration give cause for concern on the part of attorneys asked to draft Declarations for clients and to assist in their execution and effacement. The Act requires that declarants be adults, without, however, defining adulthood. One would

expect that the normal definition of an adult as one eighteen years of age would apply, and that thought is buttressed by a reference over to the South Carolina statute governing post-mortem gifts of body parts, which allows persons of that age to make such gifts.²⁸ The Act would be improved, however, by a clarification of the meaning of its use of "adult."

"Terminal condition" is defined in the Act,²⁹ but it is also and further defined in the Act's form of Declaration,³⁰ leading, perhaps, to some confusion. The Act's "injury, disease, or illness from which ... there can be no recovery,"³¹ becomes, in the Act's form, "an incurable injury, disease, or illness ... a terminal condition."³² Where the Act posits "death is imminent without the use of life-sustaining procedures,"³³ the Act's form reads, "death will occur without the use of life-sustaining procedures and where the application of life-sustaining procedures would serve only to prolong the dying process."³⁴ The Act's "the person's present condition is confirmed by a physician other than the attending physician to be terminal"³⁵ and that to be within a "reasonable degree of medical certainty,"³⁶ becomes, in the Act's form, "certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician."³⁷ Revision of the Act must involve a careful consideration of the clarity of the definition of the circumstances in which the Declaration becomes effective and then governs medical and surgical treatment decisions.

The Act further requires that the declarant in a terminal condition³⁸ be administered "active treatment for at least six hours prior to the physician's acceptance of a declaration."³⁹ Presumably, that last means that that period must pass prior to the physician's giving effect to the Declaration, but it should be revised to make that clear.

"Active treatment" is defined as that due a person "in the absence of any terminal condition."⁴⁰ Presumably, this requirement was tacked on to

establish the safeguard of a minimum period of minimal care preliminary to and, perhaps, in some cases in avoidance of the need for putting a Declaration into effect. It hardly seems appropriate, advisable or even likely, however, that a physician will subject a patient in a terminal condition to a course of treatment suitable for non-terminal patients for any period of time as a preliminary to, let alone in an attempt to avoid, putting a Declaration into effect. Instead, the physician will deliver the level of treatment due terminal patients during the grace period. It seems, therefore, that the required six hours of active treatment should be defined with reference to the treatment appropriate to the patient's true condition whatever that might be. The Act needs revision in this respect.

3. Revocation of the Declaration

The Declaration is ineffective if revoked and the Act provides for methods of revocation.⁴¹ Declarations may be revoked "by the declarant without regard to his physical or mental condition."⁴² Revocation by a verbal expression communicated by the declarant to his attending physician is one allowable method.⁴³ Combined with the ease and the simplicity of the various methods of revocation, including a mere verbal expression provable by parol, this establishment of seemingly universal capacity to revoke a Declaration puts into serious question the utility of making a Declaration.

If a declarant, entirely incapacitated mentally at the time requested to do so, may effectively revoke his earlier Declaration by destroying the Declaration or directing another's destruction of it,⁴⁴ by signing and dating a written revocation "expressing his or her intent to revoke,"⁴⁵ or by a verbal expression of his intent to revoke,⁴⁶ then that declarant's wishes are at the mercies of any physician or other person in contact with the declarant at the time he finds himself in a terminal condition. Any person opposed on principle to, reluctant to effectuate or merely nervous

about the validity of a Declaration might then override the Declaration by the simple expedient of asking, and perhaps getting, the incapacitated declarant to assent to a revocation.

If, instead, the Act's two mentions of the declarant's "intent to revoke"⁴⁷ are to be read to modify the meaning of the language "without regard to his ... mental condition," so that the latter is not taken to allow an incapacitated declarant to revoke a Declaration, he not being able to form such an intent, then the Act requires revisions to make that interpretation clear. Reliance on the courts to make that connection and to come to that conclusion may engender significant expense and delay in the individual case.

There are other problems raised by the Act's statement of the methods of revocation. Suppose a Declaration is executed in multiple originals. Will destruction of one of the originals effect revocation of just that one original or, rather, of all of them? Where a Declaration is revoked by destruction,⁴⁸ at what point in time is the revocation effective?⁴⁹ As to the timing of the effectiveness of written revocations,⁵⁰ a matter dependent upon communication of the revocation to the attending physician, may any person communicate the revocation on behalf of the declarant or is the Act's reference to the means of communication meaningful? As to revocations by verbal expression communicated by the declarant to the attending physician,⁵¹ why does the Act contemplate the possibility of the time of the revocation being different from the time of its communication to the physician, how could that occur? These questions need answers and the Act needs revision accordingly.

4. Consequences of an Effective Declaration

a. Medical Consequences

An adult's duly executed, unrevoked Declaration, given the defined medical conditions,⁵² is supposed to result in the withholding or withdrawal of "life-sustaining proce-

dures."⁵³ There are problems with the Act's definition of "life-sustaining procedures."

If death will occur "whether or not"⁵⁴ such procedures are utilized, they are arguably not life-sustaining procedures, and, perhaps, there are no life-sustaining procedures for that patient. Evidently, the Act should be revised to define life-sustaining procedures as those such that "death will occur without the use of such procedures." That is the formulation which appears in the Act's form.⁵⁵

The exclusion from the definition of life-sustaining procedures of "medication" and of "treatment, nutrition and hydration for comfort care and alleviation of pain"⁵⁶ seems to carry with it the implication that no physician is relieved of responsibility for supplying such procedures by the existence of a Declaration.⁵⁷ Thus, the physician seemingly continues obligated to supply such procedures, at least for the purposes of comfort care and the alleviation of pain. This, however, seems to be in partial conflict with the recently adopted statement of the American Medical Association which allows for dispensing with medication, nutrition and hydration without qualification.⁵⁸ Perhaps, instead, although it hardly seems likely that this was the legislative intent, the Act is to be read merely as excluding these items from the group of life-sustaining procedures, as to which a Declaration is necessary to justify withholding, and thus to indicate that these items might be withheld even without a Declaration. The Act requires clarification and, perhaps, some revision in respect of medication, treatment, nutrition and hydration.

b. Legal Consequences

The withholding or withdrawal of life-sustaining procedures, in accord with a Declaration and the Act,⁵⁹ does not constitute suicide on the part of the declarant-decedent.⁶⁰ Nor does it lead to civil or criminal liability on the part of the physician acting on the Declaration.

A physician who acts on a Declaration "is presumed to be acting in good faith [and] is

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immune from civil or (sic) criminal liability."⁶¹ The physician must yet avoid violating "the standard of reasonable professional care and judgment under the circumstances"⁶² to be so immune; and he must not fail to effectuate a Declaration altogether if he would avoid engaging in "unprofessional conduct."⁶³

Otherwise, the physician and other persons involved with the declarant and acting on or in connection with the Declaration need to avoid coercion of the declarant,⁶⁴ fraudulent inducement of the execution of a Declaration,⁶⁵ the knowing giving of false information relative to a Declaration,⁶⁶ and affirmative and deliberate acts and omissions to end life.⁶⁷ Thus, they will avoid civil⁶⁸ and criminal⁶⁹ liability under the Act.

Physicians and other persons anticipating being involved in the health care of a declarant or of a prospective declarant need to be aware of the various civil and criminal penalties thus associated with the misuse of the Act. It should be apparent, however, that the Act's cursory mention of the mere existence of the penalties falls far short of an adequate statement of the actual operation of such penalties. The vagueness and overly broad statement of the penalty provisions may turn out to be a very important factor in the workability of Declarations under the Act.

While the Act does state that "a physician who relies on a declaration executed under this act, of which he has no actual notice of revocation ... is presumed to be acting in good faith ... [and] is immune from civil or criminal liability,"⁷⁰ and it also states that "[t]he attending physician may rely upon a signed, witnessed, and dated declaration ... [in the Act's form];"⁷¹ the Act, however, then continues, "which [the form] has been signed by the declarant in the presence of three witnesses who state that ...⁷² and who [the witnesses] would not be entitled to ... [n]o more than one witness may be ... [a] witness to a declaration may not be ..."⁷³ The above-referenced factual state-

ments, concerning the execution of the Declaration and the qualifications of the three witnesses, are all matters that are very likely not going to be within the knowledge of the attending physician later asked to rely on a Declaration. The Act also states that the Declaration must be duly executed "or else the declaration shall be utterly void and of no effect."⁷⁴ and, again, that the "declaration shall have no force or effect ...,"⁷⁵ and, lastly, that if the declarant is pregnant, "the declaration shall have no force of (sic) effect during the course of the declarant's pregnancy."⁷⁶

The Act gives no clear answer to the question whether Declarations in the correct form and apparently, properly executed may be relied upon by physicians, let alone by other persons, not aware of defects in their execution. Nor does the Act provide a forum for deciding the question of the validity of the individual Declaration. But, of course, the Act should not provide such a forum; it should not even be necessary to go to a forum to validate Declarations in the normal case. Rather, to effectuate the policy of the Act, the protection of the declarant's effective control over decisions concerning his health care,⁷⁷ it ought to be sufficient in all but extraordinary cases to have a Declaration in the correct form and apparently, properly executed. Physicians and others ought to be able to rely on such a Declaration without risking civil and criminal liability. Apparent, proper execution of a Declaration in the correct form should self-validate the Declaration.⁷⁸ The act needs revision to make it clear that such Declarations are self-validating.

F. Conclusion

Attorneys need to be aware that the law that is coming to govern the so called Living Will is no simple matter. Experience will teach us that the giving of directions concerning the making of life and death decisions, in the expectation that they will be binding upon our physicians and our families after we are no longer able to make such decisions on

our own, is in reality a very complex matter. The governing law is already complex, as shown above, and it is bound to become more complex whether or not the Death With Dignity Act is revised as suggested in this article. Revision of the Act would only avoid the delay, the expense and the uncertainty involved in the development of the law through the decision of individual cases on appeal. Meanwhile, attorneys should recognize the various problems presented by the Act as it has been enacted and they should be prepared to protect their clients against the exposure resulting from dealings with the Declaration Of A Desire For A Natural Death.

Footnotes

1. Death With Dignity Act (R360, H2041, effective 3/6/86). — S. C. Acts & Joint Resolutions — (1986).
2. The author is an attorney in private practice in Columbia. Formerly an Associate Professor of Law at the University of South Carolina School of Law, teaching trusts and estates and probate law, he has also been Reporter of the new South Carolina Probate Code.
3. State 4B (Columbia, S. C. 3-23-86).
4. Letter of Robert S. Wells, Executive Director of the S. C. Bar, *The State* 16A (Columbia, S. C. 3-27-86).
5. Undated Letter of Society For The Right To Die, New York, New York, with enclosed form of Declaration.
6. J. LeBlanc, The South Carolina Death With Dignity Act, *The Transcript* 8-9 (April, 1986).
7. See Act §5 for the Act's form of Declaration.
8. As to the definition of "adult," see text accompanying footnote 28.
9. Act §3.
10. Act §5, last paragraph.
11. See Act §5.
12. See Act §5.
13. See text accompanying footnotes 15-17.
14. J. LeBlanc, The South Carolina Death With Dignity Act, *The Transcript* 8-9 (April, 1986).
15. Act §5, last paragraph.
16. Act §5.
17. Act §5.
18. Act §5A requires an Ombudsman as witness to Declarations entered into by patients of hospitals, and skilled and intermediate care nursing facilities.
19. Act §5A, second paragraph.
20. J. LeBlanc, The South Carolina Death With Dignity Act, *The Transcript* 8-9 (April 1986).
21. Act §3; see text accompanying footnote 28.
22. Act §2d. See text accompanying footnotes 29-38.
23. Act §5B.
24. Act §3. See text accompanying footnotes 38-40.
25. Act §2b. See text accompanying footnotes 53-58.

26. Act §3.
27. Act §12.
28. S. C. Code §44-43-330(a).
29. "Terminal condition" is defined as existing when "to a reasonable degree of medical certainty (i) there can be no recovery, and (ii) death is imminent without the use of life-sustaining procedures." Act §2d.
30. The Act's form of Declaration, in its third paragraph, states that, "[i]f at any time I have an incurable injury, disease, or illness certified to be a terminal condition by two physicians ... and ... my death will occur without the use of life-sustaining procedures and where the application of life-sustaining procedures would serve only to prolong the dying process, ..."
31. Act §2d.
32. Act §5.
33. Act §2d.
34. Act §5.
35. Act §3.
36. Act §2d.
37. Act §5.
38. Actually the Act §3 posits "life threatening illnesses that are diagnosed as terminal," to further confuse the issues of definition and expression addressed in the text accompanying footnotes 29-37.
39. Act §3, second paragraph.
40. Act §2e defines active treatment as "the standard of reasonable professional care that would be rendered by a physician to a patient in the absence of any terminal condition including but not limited to hospitalization and medication."
41. Act §6. The act requires that the Declaration set forth the methods of revocation in bold-face print. Act §5, last paragraph; see text accompanying footnote 10.
42. Act §6.
43. Act §6.3.
44. Act §6.1; see the Act's form of Declaration, published in J. LeBlanc, The South Carolina Death With Dignity Act, *The Transcript* 8-9 (April, 1986), for the full text of Act §6 on the methods of revocation of Declarations.
45. Act §6.2; see footnote 44.
46. Act §6.3; see footnote 44.
47. See Act §§6.2 and 6.3 for their references to "intent to revoke." Note that Act §6.1, allowing for revocation by destruction of the Declaration, has no reference to the declarant's intent to revoke.
48. Act §6.1.
49. Compare the §6.1 coverage of this issue with that with respect to revocations by written instrument, Act §6.2, and those by verbal expression, Act §6.3.
50. Act §6.2.
51. Act §6.3.
52. See text accompanying footnotes 29-40.
53. Act §3. "Life-sustaining procedures" is defined as procedures "which would serve only to prolong the dying process ... where, in the judgment of the attending physician, death will occur whether or not (sic) such procedures are utilized ... [not including] the administration of medication ... [nor] treatment, nutrition, and hydration for comfort care or alleviation of pain." Act §2b. Compare the March 15, 1986 Statement of the Council on Ethical and Judicial Affairs of the American Medical Association, "[f]or humane reasons, with informed consent, a physician may

do what is medically necessary to alleviate severe pain, or cease or omit [life prolonging medical] treatment to permit a terminally ill patient whose death is imminent to die. ... Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life prolonging medical treatment. Life prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration."

54. Act §2b.
55. Act §5.
56. Act §2b.
57. In actuality, Act §2b states that the Act's definition of life-sustaining procedures is not meant to affect (negate?) the responsibility of the attending physician to provide the treatment, nutrition and hydration, while omitting to so refer to the medication as well.
58. See footnote 53. Note that the Act refers to "treatment, nutrition and hydration for comfort care or alleviation of pain." Act §2b. While not making a similar distinction with respect to medication, the Act seems to distinguish between, for instance, nutrition for comfort and to stop pain and nutrition for all other purposes, e.g., simple survival, and, thus, to allow a Declaration to have the effect of dispensing with the latter but not with the former.
59. Act §3.
60. Act §9.
61. Act §7.
62. Act §7.
63. Act §8; this section does purport to save the physician who, unwilling himself to effectuate a Declaration, makes "reasonable efforts to effect the transfer of the patient to another physician who will effectuate the declaration." Presumably, there is no unprofessional conduct on the part of that physician.
64. Act §10 states that no person "is required to sign a declaration ... as a condition for ... insurance ... medical treatment or ... being admitted to a hospital or nursing home facility." Act §14 criminalizes the coercion and the fraudulent inducement of the execution of Declarations.
65. Act §14 defines as murder the coercion and fraudulent inducement of the execution of a Declaration followed by withdrawal of treatment or nontreatment resulting in death.
66. Act §13(A) defines as murder the knowing giving of false information relative to a Declaration followed by the withholding or withdrawal of life-sustaining procedures resulting in the declarant's death. Act §13(B) states that where such false information leads not to the death of the declarant but, rather, to "further expenses ... as a result of the withdrawal or nontreatment, in caring for the declarant, the person [who provides the false information] is responsible for the payment of those further expenses."
67. Act §11 expressly denies approval to "mercy killing," while permitting "the natural process of dying."
68. Act §13(B).
69. Act §§13A, and 14.
70. Act §7.

71. Act §4.

72. Here and hereafter various factual statements appear in the Act; they are omitted from this text because of their length. See Act §4.3.

73. Act §4.3.

74. Act §5, last paragraph.

75. Act §5A.

76. Act §5B.

77. The Act's preamble states its policy: "adult persons have the fundamental right to control the decision relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of terminal condition," and also the Act's purpose: "that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves."

78. The Uniform Rights of the Terminally Ill Act (URTIA), offered for enactment by the National Conference of Commissioners on Uniform State Laws, includes such a provision. URTIA §11, 9A U.L.A. 1986 Supp. 455. The URTIA is a valuable model of reform available to South Carolina legislators interested in the revision of the Death With Dignity Act.

The Transcript

(July, August, 1986)



South Carolina Nurses' Association

1821 GADSDEN STREET
COLUMBIA, SOUTH CAROLINA 29201
TELEPHONE 252-4781

I am Marilyn H. Koeber, appearing on behalf of the South Carolina Nurses' Association, Gerontological Nursing Special Interest Group.

Speaking for my registered nurse colleagues, I'd like to share with this audience what nursing has accomplished and what nursing plans to do to make real nursing's commitment to the health and well being of older adults in South Carolina.

First, nursing has an excellent track record both of work and of commitment to the exuberant well being of older people. The American Nurses Association was the very first health professional association to support health insurance for older Americans.....way back in 1958. More lately and more locally, South Carolina nursing has been involved with and for older adults in three major areas: in training, in research and in service to older adults. I'd like to give a few examples of accomplishments in each of these three areas:

Training

- 1) the University of South Carolina, Columbia, College of Nursing provides every undergraduate nursing student an entire semester of clinical and classroom experiences with older adults.
- 2) The College of Nursing at USC-Columbia developed in 1984 a gerontological nursing master's degree program with a large number of

Constituent, American Nurses' Association

students currently enrolled.

- 3) The professional nursing organizations all have called repeatedly for additional training in aging and for good quality learning experiences for nursing students and for working nurses. All nursing programs in South Carolina have worked hard to accomplish this aim. 4) Nurses also do training in the state by teaching in every Summer School of Gerontology in SC and lately have provided a considerable amount of high quality, low cost training for Department of Mental Health staff and mental health specialists.
- 5) The College of Nursing at USC, Columbia, also has just received Federal funds to establish a statewide geriatric nutrition training program.

Research:

Another area where nursing works for older adults is in its research which often focuses on issues and problems relevant to older adults. For example, current research projects include work on knowledge of cancer and among older adults, self breast examination practices of older adult women, improving self esteem among depressed institutionalized older adults, stress of the caregivers of older adults and identifying older adults' practice of health promotion activities.

Service:

Last, perhaps nursing's best known avenue of demonstrating commitment

to older adults is in the realm of service. Clemson University's College of Nursing sponsors a nursing clinic wherein older adults may receive at low cost a wide range of disease-preventive and health promotion services from nurses. The College of Nursing at USC, Columbia has contracted with the Council on Aging of the Midlands to provide the registered nurse surveillance and program management for homemaker and respite program of that agency---providing highly skilled master's degree nurses the frequent contact with older adults in their homes which will assist them in their problem-solving. An area of great need for nursing practice, present and future, is the care given older adults in nursing homes. The 1983 Institute of Medicine report recognized the lack of knowledge and skills among current nursing home nursing staff. To some extent that factor may be responsible for the U.S. Senate Special Committee on Aging May, 1986 Nursing Home Care Staff Report which cited South Carolina's skilled nursing homes with significant percentages of deficiencies in inspection reports. On a brighter note, the Robert Wood Johnson teaching nursing home demonstration project in several areas of the nation has demonstrated fully that nurse involvement in nursing homes can improve the quality of life for nursing home residents, if there are enough appropriately prepared nurses meaningfully involved in the nursing home. To further insure to the public that good standards of excellence are established and recognized, nursing itself has developed a certification process in most specialties of nursing practice. One of those areas of excellence is in gerontological nursing.

Nursing is also working hard to move with health care in general outside the hospital walls to where the client is: in the workplace and in the home. Nurses are a vital part of case management and provide unique service in comprehensive, coordinated care to the older adult with complex needs who lives in the community. A major objective of nursing in South Carolina is to improve access to nursing for older adults. We believe that access to registered nurse knowledge and skills will improve the life and well being of older adults.

I urge this committee's recognition of nursing's aim for older people. I further urge this committee and this public to help nursing make real its commitment to the health and well being of older adults in South Carolina by sharing with us your ideas and your enthusiasm.

By Leon Powell, 7611 Terry St, Columbia, SC 29209, 776-1764 phone

10-1-86

If my 88 year old mother is here I will introduce her as a specific example of a person who has no institutional place to go based on financing by social security, medicare, and medicaid. If I do not introduce her it means that she was unable to attend.

This year my mother became messy around the house. In July 1986 I experienced limited knowledge of trying to obtain nursing home intermediate care. All places had a long waiting list. However I was allowed to admit her for intermediate care for two months evaluation. The records of the Brian Nursing Center, Forest Drive reflected that physically, mentally, and hygienically in August 1986 she was in too good a shape to qualify for intermediate institutional care. This record conflicts with my home experience with my mother. To account for the institutional evaluation difference, in my mind, is that maybe the working aids were not fully aware that a good report was not doing my mother any favors, or that the close proximity to three other patients in the same small room may have stimulated her to be near perfect hygienically.

The patients not qualifying for intermediate care fall through to what would appear ^{to be} a safety net of boarding home care. Needy patients do not qualify for boarding home care.

1. First, the boarding home gives priority to cash customers.
2. Second, the boarding home does not want old, old people.
3. Third, the boarding home does not want patients of any age who mess up a rug (and I do not blame them).
4. Fourth, boarding homes select the best patients they can get, and that selection does not include volunteering for disagreeable house cleaning. They want the youngest, healthy, alert, old person who has a number of years left in good housekeeping.

We need a level of care physically and financially attached to the intermediate nursing care institution; so that the two levels can decide within their own organization which level of care the patient qualifies for and not bounce the patient out the door and say go find a boarding home which does not really exist for the needy.

I have enclosed my mother's experiences at home for the month of September 1986. We have papered a yellow brick road from her bed to the bathroom. And have turned over chairs and removed cushions in order to restrict her to one ~~plastic~~ vinyl covered chair. She is worse in September than she was in July. It makes for better reading than spoken.

Elderly Support Facilities:

Financing

SKILLED NURSING

Medicare plus Medicaid

INTERMEDIATE NURSING

Ditto

Old elderly not qualifying for above

NONE *

BOARDING HOMES

First choice is cash
furnished by patient

BOARDING HOMES

- * This group selects the healthier new elderly-- leaving the old and sometimes messy elderly with no facilities. With waiting lists up to two years, even new elderly have access problems. If patient messy, say on a rug, would result in rejection.

Second choice is lesser
funds of medicare and
medicaid.

Iva Powell, age 88, experiences at home at 7611 Terry St.,
Columbia,, SC 29209 September 1986

| <u>Date</u> | <u>Code</u> | <u>Date</u> | <u>Code</u> |
|-------------|-------------|-------------|-------------------------|
| 1 | | 16 | UF & BF |
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| 3 | | 18 | UF |
| 4 | BC | 19 | BF |
| 5 | BC | 20 | |
| 6 | BF | 21 | |
| 7 | UF & BC | 22 | UC |
| 8 | UF | 23 | BC |
| 9 | BC | 24 | UF |
| 10 | UF | 25 | UFT |
| 11 | | 26 | UFT & BFC |
| 12 | UF & BC | 27 | U bed |
| 13 | UC & BC & L | 28 | |
| 14 | L | 29 | BFC |
| 15 | BC | 30 | BFC - U-bed + BFC |

Legend

B is bowels

C is clothing

F is floor

L is lost--found in car back seat

T is trail

U is urine

She cannot climb into a tub. Balance too unsteady to wash.

Mary Heriot
S.C. Federation of Older Americans
3302 West Campus Road
West Columbia, South Carolina 29169
Phone: 796-9672

I am Mary Heriot, speaking on behalf of the S. C. Federation on Aging. Our organization wants to take this opportunity to thank the Joint Legislative Committee on Aging for all that it has done for the state's older population. The Committee's efforts have helped to make South Carolina a leader in the field of aging.

As all of you know, the aging population is increasing at a faster rate than is any other segment of the population. Given both the increased life expectancy and the decreased birth rate, this trend is going to continue and even to accelerate for the foreseeable future. We, therefore, want to stress the need for both long-term and short-term planning.

Several years ago, Governor Riley appointed a "Blue Ribbon Committee on Aging". This Committee developed a state plan for aging to the year 2000. We request that this plan not be shelved when this governor goes out of office. We would like to suggest that a special committee of senior citizens be appointed to review and update, if necessary, this plan and to determine priorities for implementation.

The Federation on Aging recommends that all State, Regional, and County Plans for Aging be comprehensive plans which include service plans for persons who can pay on a sliding scale basis, as well as for those persons who cannot pay. We suggest that planners consider ways of accepting volunteer services either from the client when he recovers from an illness or from members of the family as a method of paying for service.

We recognize that most persons plan for their own retirement when they are between the ages of 55 and 65. We have noted that with the closing of plants and mills and the general emphasis on reducing costs, many people in this age group have lost their jobs and have been unable to find suitable new employment. We strongly recommend that the State aggressively enforce its Human Affairs Law which prohibits age discrimination in employment. Citizens must not be denied the opportunity to prepare for their own retirement years.

Older people are less homogeneous than any other age group. Time makes us more different--not more alike. We feel that the state should eliminate its mandatory retirement age. It should also dispense with the prohibition of engaging a consultant who is over the age of 70. Just think--the State could not hire or pay for consultation either Ronald Reagan or Strom Thurmond!

We think that the State should plan for share-a-job programs and more part-time employment, so that people who are preparing for retirement can ease into this radical lifestyle change. Incidentally such programs benefit other age groups, too--such as mothers and fathers of young children, some handicapped people and already retired persons.

The State should enact legislation that would make it illegal for an agency to deny services on the basis of age. Most State Agencies would surely say that their services are available to all ages; nevertheless,

subtle discrimination in services does exist. Those agencies that do not serve a reasonable proportion of older persons should be required to publicize their services where older people could be expected to get the information.

And lastly, we are aware of the fact that many South Carolinians have inadequate health insurance. Medicare is so flawed while Medicaid is so restrictive! The State should study the possibility of implementing an uninsured health insurance pool much like the uninsured motorists' pool.

Leslie Gilbert
SC Retired Educators Association
421 Zimacrest Dr.
Columbia, SC 29210

The South Carolina Retired Educators Association is an organization that is devoted to the general welfare of approximately 5000 retired educators in South Carolina. Even though there are more potential members, we are asking for help that would ease the financial burden on the older retired members, non-members, and state members.

As you realize, the salaries of present educators have risen considerably during the past few years, and we are happy for them, but our greatest concerns are for the older retiree who spent a lifetime in his/her chosen career and received a very low salary. There were some who worked for script, some received \$60.00 a month, and even some who are recent retirees received \$75.00 a month in the beginning. The older ones were required to work until the age of 65 before retiring, and have at least 35 years of service. Their base pay is low, and each time an increase is allowed, it is still small compared to recent retirees' increases. There have been some years that bonuses have been given, but the amounts were not added to the base pay in order to improve their financial base.

We request a plan that would at least help the older retirees. We refer to it as the "one-plus-one" plan --

We recommend that each retiree have added to the base pay \$1.00 per month for the years of service plus \$1.00 per month for the years of retirement. As an example: 30 years of service plus 20 years of retirement would give the retiree a monthly increase to the base pay of \$50.00. This is a one-time request that should improve the future base pay of retirees when a percent increase is allowed.

A cost estimate has been given by the Director of the S. C. Retirement System that predicts that for all retirees to get this increase effective July 1, 1987, it will cost approximately \$10 million for years of service and approximately \$3.7 million for years of retirement. But, if the plan were given for the retiree who retired on or before July 1, 1972, it would cost approximately \$1.8 million for years in service, and approximately \$301 thousand for years of retirement.

Our second request is for an increase in the homestead exemption for elderly homeowners from \$20,000 to \$30,000 to compensate for the high rate of taxation. Our retirees are most anxious to maintain their own residences, but recent increased assessments are making it more difficult.

Third, we endorse the South Carolina Commission on Aging's bill which would provide In-Home-Services for all older South Carolinians who need that support. Such services as: Homemaking, personal care, respite care, health maintenance service, adult day care, medical transportation, meals on wheels, or any other service deemed necessary.

The steady growth of the older population, both in absolute numbers and as a percentage of the total population, has affected all aspects of society, including the area of health.

The status of personal health in the years after 65 continues to apply greater stress on the financial health of society. The demand for long-term care looms over all of us. People over 65 compose 12% of the population but account for 30% of medical care costs. Today, 56% of Federal health care expenditures are designated for this group.

Infectious diseases have declined overall. We are now faced with disability and death from widespread chronic conditions, the so-called "lifestyle diseases," like lung cancer, diabetes, and heart disease. Eighty percent (80%) of older people suffer from one or more of these chronic conditions and half of all older people are limited in their daily activities as a result.

On the bright side, because these diseases are related to the way we live, they can be affected by changes in behavior. For example, the risks and complications of bronchitis and emphysema could be reduced by cutting down or eliminating smoking. Influenza and pneumonia, still the 5th leading cause of death, are preventable through vaccination, if only older people knew about such preventive treatment and sought it out.

The shopworn maxim about old dogs not being able to learn new tricks does not apply to health promotion. National marketing studies and the experience in this state indicate that older people are willing to make changes that offer the chance for more independent living.

A number of areas are of special interest to people over 65:

- Moderate exercise on a regular basis can strengthen the heart and circulatory system, reducing the chance of stroke, and increase flexibility.
- Modest attention to nutrition could avoid many cases of adult onset diabetes and increase overall resistance to other ills.
- Safety is not just an academic concern. Many older people fear falls because they remember seeing their older relatives become increasingly dependent as a result. Simple environmental changes can reduce the chance of falls.

The Commission on Aging and DHEC have developed the Live Better Longer project at Governor Riley's request. Using existing operating funds, the project works to encourage interest in promoting healthy independence among older people.

Local programs are the key to promoting health before disability strikes. These programs have started a variety of projects aimed at avoiding the health problems older people fear and at the same time adding enjoyment to their clients' lives.

Some programs take a traditional education approach. The HCA Aiken Regional Medical Centers and the Lower Savannah Council of Governments joined to provide senior citizens with lectures given by doctors and technicians. During the presentations, participants could ask questions they would not normally ask in a doctor's office. Over the past three years, the lectures have covered subjects like allergies, nutrition, dental health, and depression.

Some programs are based on community action. The St. James South Santee Community Center outside McClellanville used a \$600 stake to establish such a program. Their project trains senior volunteers to help homebound senior citizens improve their nutrition and increase their exercise. It has tapped the energy and spirit of older volunteers, benefitting both those doing the visiting and their homebound peers. Its participants have shown dedication and imagination in stretching the initial funding over three years. This program will be featured in a documentary to be broadcast from ETV as part of a statewide teleconference on health promotion for older people November 13.

In recognition of the spirit, organization and effectiveness of these programs, and others in Irmo, Charleston, and Columbia, the state has honored them with the Governor's Health Promotion for Older South Carolinians Award.

Programs of all types and sizes are being conducted across the state. Most are local in focus. A survey conducted by the Live Better Longer project showed the primary subject areas receiving attention were nutrition, fitness, safety, and effective use of community resources to help families cope with the demands of aging.

The same survey also asked what kinds of support community programs wanted to reinforce and expand their services. An overwhelming percentage requested printed and audiovisual materials, training, and the names of others working in the area of health promotion.

Using this information, the Commission on Aging and DHEC have concentrated on supporting this growing network in three ways:

- providing information and technical assistance within the limits of general operating funds
- recognizing existing programs like the award-winners just mentioned, and
- encouraging new efforts by providing community groups with support materials and contact with experienced colleagues.

Given the economic picture this year, no budget request has been made for these efforts. But given the growing demands in South Carolina and the national attention to older health promotion, assistance will be needed in the future. The keys to making the most of local efforts are coordination and concrete support.

Coordination can avoid duplication of effort, one of the greatest dangers in isolated projects. A central project headquarters with distinct and dependable funding can assure a steady source of technical assistance and networking. Serving a population this size would require two (2) staff trained in health promotion, information and community organization methods and one (1) clerical support person. Where such a unit might be housed is less important than the fact that it exists at all. Of course, the staff of Commission on Aging and DHEC who are currently working in this effort would continue to offer input.

Support for these crucial local programs should include seed money to translate their enthusiasm into action. The amounts of money for individual projects could be modest. Any recipient should be required to evaluate the impact of their efforts. The result could be to replicate successes and encourage the creation of programs in underserved areas. This tangible support, coupled with recognition like the Governor's Award, can stimulate a project amazingly.

Aging is a natural process, one that may include some diminishing of a person's reserves. More than ever, the chronic ills still accepted by many as inevitable can be prevented through good health promotion. The knowledge exists but it must be shared and applied.

Community action is the key. For these groups to be most effective, they need coordination and concrete support in terms of expertise, materials, and seed money. The success of health promotion projects for older people will do more than just add years to life, their work can truly add life to years.

Thank you for your consideration and your continued support.

Dr. Ernest Furchtgott
Dept. of Psychology - USC
Columbia, SC 29208

TESTIMONY PRESENTED TO THE
JOINT LEGISLATIVE STUDY COMMITTEE
ON AGING - OCTOBER 1, 1986

by Ernest Furchtgott, Director
South Carolina Gerontology Center

Chairman Harris, Distinguished Members of the Committee,

First, I would like to express my appreciation for the opportunity to testify before your Committee. The South Carolina Gerontology Center, a consortium of Clemson University, The Medical University of South Carolina, South Carolina State College, The University of South Carolina, and Winthrop College is now in its second year. The Center's major aims are to enhance gerontological research and education in the state supported institutions. We are available for consultation and assistance to various state agencies and other organizations which need assistance with research problems. There is no other state agency which has personnel resources equal to those found at the 5 consortium member institutions. We publish a Newsletter and a Directory of Personnel with expertise in gerontology. A 1986-87 edition will be available shortly.

We are currently gathering information on available gerontological data bases on older South Carolinians. Various data on this population have been gathered by various organizations. Thus, the Budget and Control Board's Division of Research and

Statistics has an analysis of the US Census Data for South Carolina, data on hospital admissions, discharges, diagnoses and disposition of patients, some survey data on physicians' and dentists' office visits, and some other selected data. Several, not all, of the Regional Area Agencies on Aging have data for their own regions. The Department of Mental Health has data on admissions, utilization, and other information on seniors who were in- or outpatients in their facilities including their long term care facilities. The Central Midlands Regional Planning Council has various types of survey information on about 6500 older persons in the region. The S.C. Health and Human Services Finance Commission has its own data on long term care patients. The Department of Mental Retardation has its data set. The VA has collected locally data on veterans. Despite this seeming wealth of materials, important for planning and policy decision, there is no single source for all of this information. The Center is in the process of developing a readily available index. This should also be available shortly.

We provide a list of speakers and their topics in gerontology. We are gathering an index of available library resources in gerontology. In addition, we serve as a referral center for diverse inquiries on aging, especially on technical questions.

During our first year of existence the Center was funded by the member schools. For 1986-87 the Center received a \$25,000 appropriation from the State. I might point out that most states have at least one gerontology center at their state supported institution, many have more. Georgia has two centers, Alabama has also two, Virginia has two, and so on. In a survey which we

conducted last year, the median state appropriation for Centers was well over \$70,000.

The low priority which gerontological research and education receives in South Carolina could also be deduced from the \$300 million research proposal put together by the presidents of Clemson, MUSC, and USC. While a very large number of subject areas were included and parceled out in the proposal, gerontology was not one of the areas included. Yet we all know that currently about 28% of the total federal budget, approximately \$273 billion will be spent for the benefit of older Americans. Unfortunately, the last time that comparable data were collected for South Carolina was 1980-81 when this committee collected such information. While a large number of state agencies are providing services for the aged, the research efforts of these agencies is minimal since they do not have the staff for research. Furthermore, the efforts are uncoordinated.

The need for current research and information on the elderly for policy and planning purposes cannot be overemphasized. As you probably know, for the decade of 1970-1980 there was a 50.5% increase of South Carolinians over the age of 65. We had the seventh largest percentage increase of any state. For the 1980-84 period our increase was 15.5% again the seventh largest increase among the states. While many national data and information are applicable to the local level, many kinds of data need to be generated on a regional or state basis. Data from a recent study by the Michigan Office of Services to the Aged, for example, revealed the need to change that state's policies. Thus, door-to-door

transit programs, traditionally viewed as too expensive, may prove to be cheaper than large van and bus projects which got little use. Another interesting finding was that living with relatives has replaced nursing homes as the least desirable place to live. Also 82% of the elderly who owned their homes wanted assistance, especially in the form of labor for maintenance and repairs. The examples which I have given should not necessarily be used as desirable prototypes of policies for our state. They do, however, indicate that policy makers need current local information. A few years ago one of my graduate students found large discrepancies in the perception of needs by professionals and the elderly in Aiken county.

Carol Fraser Fisk, the new commissioner of the US Administration on Aging, stresses the importance of collaboration and raising public awareness about senior's needs. The New York State Association of Gerontological Educators (SAGE) has an active program of collaboration with the state office on aging. They provide technical expertise to various state agencies. It is our hope that the SC Gerontology Center will also serve this function. We are the only state in which a collaborative arrangement for gerontological research has been established for all state supported educational institutions. Your continued support for the Center is needed. We are ready to assist you whenever possible.

Thank you again for permitting me to testify.

PREPARED STATEMENT OF RONALD A. BURTON, MSW, PHD, PRESIDENT,
THE CENTER FOR SOCIAL WELFARE CONCERNS, INCORPORATED, TO THE
JOINT LEGISLATIVE STUDY COMMITTEE ON AGING, SOUTH CAROLINA
GENERAL ASSEMBLY, OCTOBER 1, 1986

Dr. Ronald A. Burton
The Center for Social Welfare
Concerns, Inc.
P.O. Box 11758
Columbia, SC 29211-9990

Mr. Chairman, I am Ronald Burton, President of the
Center for Social Welfare Concerns, Incorporated (CSWCI).
Thank you for allowing me to testify. You may recall that I
was one of the final ten (10) individuals considered for the
newly filled position, Executive Director, SC Commission on
Aging. I appreciate the opportunity to again address this
Committee, during this public hearing on issues facing the
elderly that can be handled through state legislation.

The CSWCI has an intense concern for the elderly. We
have been closely observing, with applause, the legislative
efforts by this Committee and the Joint Legislative Health
Care Planning and Oversight Committee to enhance life in its
final stages for South Carolinians. We are currently
working with the University of South Carolina College of
Social Work and the South Carolina Department of Mental
Health to seek funding for research which will identify both
the mental health problems of older South Carolinians and
how to effectively address them. Should the proposed
research receive funding, it is clear that information will
be obtained that will be useful in setting policy and in

planning for the mental health needs of our elderly population. And, among other efforts, we are engaged in efforts to provide education, through, for example, training activities and workshops, which is intended to enhance the caregivers' ability to care more effectively.

In my brief address to you today, I want to identify and highlight one specific issue which is in need of attention from this Committee, Drug Abuse Among the Elderly, including prescription and over-the-counter medications and alcohol abuse. I will close by making some recommendations to the Committee.

Drugs and the Elderly ----

Since the occurrence of adverse drug reactions is directly related to the number and frequency of drug-dose exposures, and since drugs are a very important component of the lifestyle of our elderly citizens (indeed they are part of a typical approach to health problems), then we can presume that the elderly patient, whether an outpatient or institutionalized, is unusually prone to adverse drug reactions and drug interactions.

It is necessary to be clear that the point here is not to deny the need and value of medication in the lives of elderly people. The concern is rather to point out to this Committee the need to focus its attention on "drug misuse" --- which includes a departure from rational therapeutics,

an unwholesome reliance on drugs as the solution for all problems of the elderly patient, and the drug misadventures that accompany overutilization of drugs.

Drug overutilization among the elderly has been described as "common and, while unintentional in nearly all instances, does occur and occurs frequently." For instance, while drugs can ease pain, halt infections, offset physiological changes, reduce anxiety, and bring sleep, the elderly can develop an almost ritualistic dependence upon them. Elderly patients may seek, and receive, refill permission long after a rational need for a given drug has disappeared. Overuse of over-the-counter remedies, which purportedly provide relief for a great variety of ailments, may result in a preoccupation and experimentation with medications that may lead the elderly person to an irrational regimen of drug ingestion.

Another reason to thoroughly investigate and address the problem of drug misuse is that its continuation may be unnecessarily costly and, indeed, expensive. The careless use of a few dollars' worth of drugs adds to the burden of cost borne by state government programs, insurance carriers, and by the individual aged citizen and his or her family. One conservative estimate places the overuse and over-purchase of drugs at about 50% of the elderly consumer's total drug and health product budget.

Another problem which demands your attention is alcohol abuse and alcoholism among the elderly. This is a serious public health problem. National and local surveys have

found between 2% and 10% of older men to be alcoholics or problem drinkers. Studies in nursing homes have estimated the prevalence of alcoholism among inhabitants to range from 25% to as high as 60%. Finally, of all people 65 years of age and above who were arrested in the U.S. in 1975, 58.4% were arrested for either drunkenness or driving under the influence.

I think it is clear that the issue of Drug Abuse Among the Elderly is prominent and worthy of investigation and intervention by this Committee.

Recommendations ----

(1) While I realize that Committee members are limited in their time, I strongly recommend that its representatives visit facilities and conduct investigations and hearings to learn first-hand about this issue. Similarly, it is essential that you continue your "open door" policy so that the public and professional sectors alike will be encouraged to bring incidents indicating substance abuse to your attention.

(2) This Committee might propose legislation directed toward health promotion for elderly which keeps a mindful eye on alcohol and other drug misuse. It might work with the local chapters of the National and American Medical Associations, the State Gerontological Society, and the American Association of Retired Persons toward the design of

such legislation.

(3) In closing, this Committee is encouraged to support studies and research on these and related issues for the purposes of planning and intervention. I think there is a lot of support as well as responsible and innovative thinking about both the problems elderly face and how to effectively intervene to resolve them that has not yet been accessed and that will prove highly useful, particularly in our present state of increased need and diminishing resources.

THANK YOU.

Roy L. Ferree
214 Spring Drive
Easley, SC 29640

September 9, 1986

Ms. Keller Barron
Joint Legislative Committee on Aging
P. O. Box 119867
Columbia, SC 29211

Re: Death with Dignity Act

Dear Ms. Barron:

Since I first corresponded with you, former Rep. Palmer Freeman, Sen. John Hayes, Rep. Harriet Keyserling and The Society for the Right to Die regarding the new South Carolina Death with Dignity Act (DWDA), a couple of significant events have occurred: (1) I have changed positions, being newly employed as an Administrator with the Trust Department of South Carolina National Bank and (2) THE TRANSCRIPT has recently published a lengthy and scholarly two-part article by James L. LeBlanc, Esq. regarding the DWDA and its particular difficulties. Further, to the extent that I have had the chance to talk to others regarding DWDA, the reaction has generally been negative; e.g., a recent presentation at the Greenville Estate Planning Council. The reaction is not negative regarding the need for such legislation; rather it is negative because the DWDA as now drafted is confusing and ineffectual.

I appreciate your invitation to participate in public discussion of the statute; however, because of my recent change of employment, I feel I must decline to participate personally. I hope you will accept this letter as my contribution. While the DWDA is less likely to affect me in my present position, my strong feelings contra DWDA as presently drafted continue. Merits aside, the statute is a trap for the unwary and wary alike. I think that may be very apparent from reading Mr. LeBlanc's article (THE TRANSCRIPT, Vol. 30, Nos. 7, 8, July, August, 1986). While I concur with Mr. LeBlanc in his criticisms, some of which are echoed below, there are some other weaknesses.

I have also attached a proposed amended bill. While the proposed bill may not be an end-all as far as answering questions raised by myself and others, its facility is that it is simple and could serve as a new beginning.

I. Operation of the Statute.

Before I deal with the questions involved, I believe the operation of the DWDA should be placed in context. The declaration is supposed to serve as the direction of a "declarant" 2/ for the withholding of "life-sustaining procedures" 3/ by a physician 4/ when the patient is diagnosed as having a "terminal condition". 5/ The terminal condition must be confirmed by a second physician. 6/ After "active treatment" of at least six hours 7/ the physician is supposed to be able to rely on a signed, witnessed and dated declaration, executed in conformity with the statute 8/ to withhold

treatment. The declaration must be in "substantially" the same "form" as the statutory form. 9/ If the declarant is institutionalized at the time of its execution, one of the witnesses must be an "ombudsman". 10/ The declaration has no force or effect if the declarant is pregnant. 11/ It may be revoked by the declarant "without regard to his physical or mental condition". 12/ A physician who relies on a declaration "executed under this Act", and of which he has no notice of revocation, is immune to civil or criminal liability unless it is alleged and proved he violated "the standard of reasonable professional care and judgement under the circumstances". 13/ If a physician fails to effectuate the declaration or fails or refuses to make reasonable effort to transfer the patient to another physician who will effectuate the declaration, the physician has committed "unprofessional conduct". 14/ Execution and consummation of a "declaration" is not suicide, 15/ no one can be required to execute a declaration, 16/ mercy killing is not authorized, 17/ and the absence of a declaration does not give rise to any presumption regarding "death prolonging procedures". 18/ If any one knowingly provides (or aids in the providing of) any false information "of any nature" relative to a declaration, "including but not limited" to the contents, execution or revocation, and life-sustaining procedures are withdrawn and a declarant dies, the person is guilty of murder. 19/ On the other hand, if the patient does not die, such person is responsible for the additional medical bills. 20/ Finally, anyone coercing or fraudulently inducing another to execute a declaration and the declarant thereafter dies as a result of withdrawal of life-sustaining procedures, the person is guilty of murder. 21/ In a nutshell, that's what the act provides. If a declaration is to be

operative, 22/ what must happen is (1) a declarant must execute a declaration in substantially the same form as in the statute; (2) it must be witnessed generally by non-relatives, non-physicians and non-nurses, non-beneficiaries or non-heirs, non-creditors and non-insurance beneficiaries, and before a notary public (one of the witnesses may have to be a government official) 23/; (3) the patient must thereafter be diagnosed as in a "terminal condition" ("... injury, disease or illness from which to a reasonable degree of medical certainty (i) there can be no recovery and (ii) death is imminent without application of "life-sustaining procedures") 24/; and (4) the diagnosis must be confirmed by a second, non-attending physician. 25/

II. Questions raised by the statute (DWDA) are:

- (A) Will the declaration ever be effective?
- (B) Why exclude the opportunity to designate an Attorney-in-Fact?
- (C) Can the physician act in reliance without liability?
- (D) Do we need two new murder statutes?
- (E) Why must it be ineffective in all cases of pregnancy?
- (F) Will the statute affect persons in "persistent vegetative state"?
- (G) Custody and delivery - how does the physician find out?

These questions are dealt with individually below.

- (A) Will the declaration ever be effective?

In its efforts to insure that a declarant is not irrevocably bound by his or her declaration, the DWDA statute provides that it can be revoked "without regard to physical or mental condition".26/ The import of that language is significant. While all of us labor under the impression that an incompetent or comatose patient, or one in persistent vegetative state, cannot revoke a Will, for example, the DWDA introduces a new concept of competence and consciousness. While this unfortunate language is not uncommon in other right to die legislation, 27/ unlike other legislation we do not have guidelines as to when, regardless of this language, treatment can be terminated. A review of the Uniform Rights of the Terminally-Ill Act (URTIA), promulgated in 1985, the legislation of thirteen states which enacted right-to-die legislation in 1985, and the 1985 revision of the Texas right-to-die statute, 28/ indicates that in each of these, despite revocability of a declaration, there is a time when, under statutory guidelines, physician diagnosis or by other determination, the declarant no longer has the ability to revoke or, on the other hand, the declaration is effective as the declarant's last instructions. 29/ For example, in URTIA, while the revocability survives competency or consciousness, 30/ the declaration becomes "operative" when the attending physician determines that the declarant is no longer able to make decisions regarding administration of life-sustaining treatment. 31/ The New Hampshire, Utah, Colorado, Connecticut, Indiana, and Maryland statutes omit the "... without regard to physical or mental condition" language 32/; the Oklahoma statute makes the declaration effective until revoked 33/; the Arizona statute makes the declaration effective if at the time of the decision to withhold treatment, the patient lacks capacity 34/; the Iowa,

Maine, Missouri, Montana and Texas statutes become effective when the patient no longer has the capacity to make treatment decisions 35/; and the Tennessee statute is effective during periods when the patient is comatose or is otherwise unable to communicate with the physician. 36/ The DWDA does not deal with the issue as to when the declaration is effective or operative or, despite revocability, when the patient lacks the capacity to participate in medical decisions. Considering the consequences of a physician's actions, some reasonable guidelines are needed, and a physician is taking a substantial risk by withholding treatment without such statutory guidelines.

(B) Why exclude the opportunity for the declarant to designate an Attorney-in-Fact to make decisions?

Of the thirty-seven states that have enacted right-to-die legislation, ten have provisions for consultation with, or designation of someone other than the declarant to act in the event of terminal illness, under varying circumstances. 37/ Since South Carolina was one of the earlier states to adopt a Durable Power of Attorney statute, it seems only reasonable that the DWDA incorporate some provisions for designation by a declarant of a close family member as Attorney-in-Fact to act on behalf of a terminally-ill patient when the patient no longer possesses the capacity or capability to act. In the last year, Iowa, Utah, and Texas have provided for such consultation or designation of someone other than the declarant to act. 38/ It is the family members who, in absence of statute or declaration, will usually be consulted when the patient is not capable of participating in medical decisions.

It is also these family members who will no longer be consulted under DWDA. In my opinion, this is a severe limitation. Whereas, before the statute, and in absence of capability of the patient to assist in medical decisions, physicians consulted with family members, the DWDA leaves him with only a document and one presently with questionable validity. Since I have only rarely heard anyone express fear that a physician would unduly prolong the life of a terminally-ill patient, 39/ the statute closes off patient and physician options in its exclusion of consultation with family members. With the exclusion of the Attorney-in-Fact option, and the foreclosing of consultation with family members, the statute has made the terminally-ill patient's choices narrower than they were prior to the DWDA's enactment, in my opinion.

(C) Can the physician act in reliance without liability?

The physician's immunity from civil and criminal liability centers upon his reliance upon a document executed "under the act". 40/

However, under Section 4 of the DWDA, he may rely upon a declaration subject to certain conditions enumerated in that section. Among them are Paragraph 3 of Section 4, which spells out many, but not all, of the execution and witness requirements. Does the physician have to investigate and determine if the witnesses are proper witnesses? And what does "related by blood or marriage" mean?

There is nothing in DWDA that immunizes the physician for relying on a declaration which, upon its face, appears to comply with the act. That is

what the standard should be, absent actual knowledge to the contrary; however, the DWDA fails to make that standard clear.

And why must the witness requirements be a trap for the unwary? Without limitations on kinship degree, who can say what "related by blood or marriage" really means? The statute does not "eschew obfuscation" in this regard. Before the physician acts, in my opinion, he will need legal advice, at a very minimum. Perhaps the legislature should consider the body of law built up around beneficiaries who witness a Will.

(D) Do we need two new murder statutes?

The DWDA has provided us with two new murder statutes in Sections 13A and 14 of the Act. The former has to do with providing false information, or aiding in providing false information, regarding a declaration or its contents or a revocation. The latter statute deals with coercing or fraudulently inducing someone to execute a declaration. Of course, if this is wrongful killing, it should already be part of the criminal code. Moreover, these provisions seem to overlook the fact that perhaps no physician would or should accept a layman's word for the existence of a declaration; he would insist on seeing it and making it part of the patient's medical records. Further, in order to "murder" someone by use of a declaration, the "wrong-doer" must (1) secure the medical diagnosis of terminal condition (no hope of recovery and death is imminent) concurred in by two physicians, (2) arrange for three witnesses and a notary to witness the execution, with the incredibly strict standards under DWDA,

(3) exhibit the declaration to a physician and get him to terminate treatment, and (4) some how provide false information or coerce or fraudulently induce the making of the declaration. Even if that could be done, isn't it already wrongful killing or procuring wrongful killing? On the other hand, what about a forgery? The statute does not address forgeries.

(E) Why must the declaration be ineffective in all cases where the declarant is pregnant?

Section 5B of the DWDA renders any declaration ineffective when the declarant is pregnant. No explanation of the reasons therefore are necessary; however, the provision goes too far. It should at least have a proviso that, if in the opinion of a physician (or two physicians), maintaining a pregnant patient by life-sustaining procedures will not result in a live birth, to a reasonable degree of medical certainty, then the declaration should be effective regardless the existence of pregnancy. 41/

The second paragraph of Section 5B is misplaced. And why would a witness serve as a witness if he had to make an affidavit of "disqualification"? I do not understand the purpose of the paragraph, and if it has any useful purpose, it does not belong in this Section of DWDA.

(F) Will the statute affect persons in "persistent vegetative state"?

Section 11 of the Act indicates that nothing in the DWDA is to be construed to authorize mercy killing, "or to permit any affirmative or deliberate act or omission to end life other than to permit the natural act of dying". The Uniform Determination of Death Act (UDDA) provides that an "individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead." 42/ When a person is in a persistent vegetative state, he is not dead under UDDA, since persistent vegetative state is neocortical death, or the non-functioning of the neocortex, not the cessation of function of the entire brain. I recite these facts and the existence of this unfortunate statute (UDDA) as a background because the average citizen believes persistent vegetative state is the classic application for right-to-die legislation. In persistent vegetative state, death is not necessarily imminent, although it seems reasonable that a person in this condition has a shortened life expectancy.

It was this persistent vegetative state which was the condition of the patient in the Quinlan 43/ case, to which case we attribute a major impetus for right-to-die legislation. In Quinlan, I believe, the patient was removed from a respirator. More recently, a New Jersey court has authorized the removal of feeding tubes in the Conroy case. 44/ The significance of this case is that, whereas in Quinlan the patient continued to breathe and lived a number of years, in Conroy the patient, although apparently without any discomfort, will starve and/or thirst to death, absent intervening causes.

Both Conroy and Quinlan patients involved a persistent vegetative state, and the obvious question is what is the difference? We can visualize the Quinlan scenario, but what about the Conroy scenario? Would Conroy be mercy killing under the DWDA? Life-sustaining procedures, as defined in Section 2b of DWDA, would seem to exclude from its definition "nutrition or hydration for comfort care or for the alleviation of pain". Would the removal of nutrition (feeding tubes) subject a physician to the charge that he has undertaken a "deliberate act or omission" precipitating the patient's death? 45/ Did the legislature even consider this issue? It would appear that a physician who was contemplating removal of nutrition or hydration should reconsider his options, since I am of the opinion it cannot safely be done under the language of the DWDA.

Further, even the removal of a respirator may place a physician in jeopardy. Since a patient must be diagnosed as being in a terminal condition, which means "to a reasonable degree of medical certainty (i) there can be no recovery and (ii) death is imminent . . . ," 46/ could a physician make that determination. In retrospect, the Quinlan patient lived years without the respirator, which negates the "death is imminent" requirement. And, if death is indeed imminent what is the justification for discontinuance of respirators, or nutrition and hydration. 47/

As drafted, the statute make it questionable whether there can be termination of life-sustaining procedures for a person in a persistent vegetative state. The "death is imminent" 48/ requirement seems a very large stumbling block. In any event, a physician would be wise to consider

his legal options because he is not clearly immunized from liability if he does withdraw life-sustaining procedures, nutrition and/or hydration from such a patient.

III. Proposed Revision of DWDA.

I have attached hereto, as Exhibit B, a proposed revision of DWDA. I do not represent it as without flaw, but its concept is much simpler than the present statute. Below is a brief comparison with present provisions:

Section 1. Same as present

Section 2. (a) "Declarant" definition clarified as adult person not otherwise incompetent.

(b) New Definition of Declaration; includes ability to use durable power.

(c) Life-sustaining procedure. Eliminates term "nutrition and hydration" in favor of "medical procedures".

(d) Unchanged from old (c).

(e) Eliminates "death is imminent" for standard that "death will occur".

Section 3. Sets objective standards for determination to terminate treatment, and eliminates requirement of active treatment since such requirement may be futile. Also makes clear that the declarant must cause the declaration to become part of his medical records (the custody problem).

Section 4. Gives the physician the immunity he should have by permitting him to rely on a declaration without inquiry into witness requirements, etc. In conjunction with Section 9, it immunizes physician acting in good faith without notice of revocation, and does not require him to make factual investigation or make legal conclusions. This is the immunity intended, but not given under DWDA.

Section 5. A mandatory form becomes suggested form, as it should be.

Section 6. Revocation becomes any action by which the declarant evidences a change of mind, as it should be.

Section 7. Ability to name an Attorney-in-Fact to act, with requisite provisions immunizing the Attorney-in-Fact and physician.

Section 8. Changes the old pregnancy provision to one with some logical standards.

Section 9. Physician immunity. See Section 4 above.

Section 10. Physician transfers unchanged from old Section 8.

Section 11. Adds provision relating to durable power to old Section 9.

Section 12. Adds provision relating to durable power to old Section 10.

Section 13. Old Section 11, unchanged.

Section 14. Old Section 12, unchanged, except that "death prolonging procedures now becomes "life sustaining procedures", consistent with the remainder of DWDA.

Section 15. Statement of policy of the DWDA, a tool of construction. The only obligation to act under the statute is upon the physician, who is immunized. No liability attaches to any other person who acts in good faith on the basis of conscience, faith or beliefs, regardless that he may be a volunteer or Attorney-in-Fact, even if it thwarts the declarant's purpose. No one, other than the declarant and the physician, should have any legal obligation. In this context, the custody issue is resolved. Custody is the declarant's responsibility, and no one else has any obligation to do anything regarding a declaration, even if he knows about it.

Section 16. I feel these are implicit in the proposed revised statute; however, since the DWDA is controversial, I felt this should be made clear.

Section 17. Effective date.

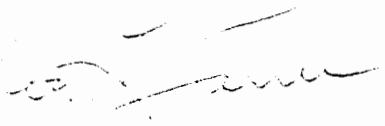
IV. Summary.

The statute as it stands is flawed. It does not provide clear guidelines for termination of treatment, nor is it reasonably simple to understand and put into effect. It may have even created problems where none existed before. An effort to amend it to do that which it is intended to do would

not require significant redrafting, but to be useable it must be amended. Until the statute is amended I would be very reluctant to represent that a declaration will be effective and perhaps even more reluctant to assume responsibility for drafting and supervising the execution thereof. The proposed amendment simplifies, and goes some distance toward resolving issues. I do not expect it answers all questions, and it is suggested as only a starting point.

I appreciate your invitation to participate in the hearings, and regret I must decline. I wish your committee success in amending the statute to carry out the purpose for which it was enacted.

Sincerely yours,



Roy L. Ferree

RLF/mh

Enclosures:

Exhibit A - Footnotes

Exhibit B - Proposed Revised Statute.

cc: Eric Silberg, 10/17/75

EXHIBIT A

FOOTNOTES

- 1/ The Death with Dignity Act (R360, H.2041, Eff. Mar. 6, 1986),
 S.C. Acts & Joint Resolutions.
- 2/ Defined in Section 2.a., DWDA.
- 3/ Id. at Section 2.b.
- 4/ Id. at Section 2.c.
- 5/ Id. at Section 2.d.
- 6/ Id. at Section 3.
- 7/ Id. at Section 2.e., 3.
- 8/ Id. at Section 4, 7.
- 9/ Id. at Section 5.
- 10/ Id. at Section 5A.
- 11/ Id. at Section 5B.
- 12/ Id. at Section 6.
- 13/ Id. at Section 7.
- 14/ Id. at Section 8.
- 15/ Id. at Section 9.
- 16/ Id. at Section 10.
- 17/ Id. at Section 11.
- 18/ Id. at Section 12. Why "death prolonging procedures" is used as
opposed to "life-sustaining procedures", a defined term, is unexplained.
- 19/ Id. at Section 13.(A).
- 20/ Id. at Section 13. (B)
- 21/ Id. at Section 14.
- 22/ As discussed infra, the declaration may never be effective. See text
accompanying notes 26 - 35, infra.
- 23/ An "ombudsman". See DWDA, Section 5A, 4, 5.

24/ DWDA, Section 2.b.

25/ Id. at Section 3.

26/ Id. at Section 6.

27/ I have used as a principal reference Handbook of 1985 Living Will Laws, published by the Society for the Right to Die in 1986. In addition to other materials, it contains the text of the Uniform Rights of the Terminally-Ill Act, promulgated in 1985, and the text of the enactment of thirteen states which adopted "right to die" legislation in 1985, and the text of the Texas statute, which was substantially revised in 1985.

28/ As reflected in Handbook of 1985 Living Will Laws, supra n.27.

29/ See, generally, URTIA, Section 3, and the following:

Arizona. Ariz. Rev. Stat. ann. §36-3205(b) first sentence.
Colorado. Colo. Rev. Stat. §15-18-104(1), and (b) of the suggested form, and §15-18-108, last sentence.
Connecticut. Publ. Act. No. 85-606, Section 2.
Indiana. Ind. Code §16-8-11, Section 15.
Iowa. Iowa Code §144A.3, second sentence.
Maine. Me. Rev. Stat. Ann. tit. 22, ch. 710a, §2922 and §2925, third sentence.
Maryland. Md. Health General Code Ann. §5-604.
Missouri. Mo. Rev. Stat. §459.025, second sentence.
Montana. Mont. Code Ann. §50-9-103(1), second sentence, §50-9-202(1).
New Hampshire. N.H. Rev. Stat. Ann. ch. 137-H:3, second sentence.
Oklahoma. Okla. Stat. tit. 63, §3105.
Tennessee. Tenn. Code Ann. §32-11-107.
Utah. Utah Code Ann. §75-2-1104(1) and para. 3 of the statutory form and §75-2-1105(b).
Texas. Tex. Stat. Ann. art. 4590h, Sec. 4A, 4B, and 4C, Sec. 5.

30/ URTIA, Section 4.

31/ Id. at Section 3.

32/ N. H. Rev. Stat. Ann. ch. 137-H:7; Utah Code Ann. §75-2-1111; Colo. Rev. Stat. §15-18-109; Conn. Publ. Act. No. 85-606 makes no mention at all of revocation; Ind. Code §16-8-13; and Md. Health General Code Ann. §5-603.

33/ Okla. Stat. tit. 63, §3105.

34/ Ariz. Rev. Stat. Ann. §36-3205(b).

35/ Iowa Code §144A.3(1); Me. Rev. Stat. Ann. tit. 22, ch. 710a, §§2922, 2915; Mo. Rev. Stat. §459.025; Mont. Code Ann. §50-9-103; and Tex. Stat. Ann. art. 4590h, Section 4A.

36/ Tenn Code Ann. §32-11-107.

37/ Handbook of 1985 Living Will Laws, p. 16.

38/ Id.

39/ See, e.g., The Physician and the Hopelessly Ill Patient, pp. 12-14. The book was also published by the Society for the Right to Die, in 1985. I have not undertaken any survey personally.

40/ DWDA, Section 7.

41/ The new Colorado statute, for example, provides such a standard. Colo. REV. Stat. §15-18-104(2).

42/ S.C. Code Ann. §44-43-460 (1985 supp.)

43/ In re Quinlan, 348 A.2d 801 (N.J. Super Ct., Ch. Div. 1975), modified and remanded 355 A. 2d 647, cert. den . 429 U.S.922 (1976).

44/ In re Conroy, 457 A.2d 1232 (Super. Ct., Ch.Div.), rev'd 464 A.2d 303 (Super Ct., App. Div. 1983), No. A-108 (N.J. Sup.Ct., Jan. 17, 1985).

45/ DWDA, Section 11, prohibiting "mercy killing".

46/ Id. at Section 2.b. My view that DWDA does nothing for the Quinlan type patient seems shared by the A.B.A. Journal regarding URTIA. See Vol 22 A.B.A.J., Sept. 1, 1986 at p.24.

47/ Handbook of 1985 Living Will Laws, p. 12, reports that the Judicial Council of the AMA supports the ethicality of withholding nutrition and hydration from irreversibly comatose patients even in absence of imminent death.

48/ DWDA, Section 2.b.

EXHIBIT B

PROPOSED REVISED ACT

Section 1. Short Name

This act may be cited as the Death With Dignity Act.

Section 2. Definitions

As used in this act:

- a. "Declarant" means an adult person not otherwise incompetent who has signed a declaration in accordance with Section 5.
- b. "Declaration" means a Declaration of Natural Death in similar form as that set out in Section 5 of this Act; provided, however, that such declaration may be made a part of a durable Power of Attorney under provision of the statutory laws of this State.
- c. "Life-sustaining procedure" means any medical procedure or intervention which would serve only to prolong the dying process and where, in the judgment of the attending physician, death will occur whether or not such procedures are utilized. Life-sustaining procedure shall not include the administration of medication or the performance of any medical procedure considered necessary to provide comfort care and/or alleviation of pain.
- d. "Physician" means any person licensed to practice medicine in this State.
- e. "Terminal condition" means a patient who has an incurable injury, disease, or illness which is a terminal condition and whose death will occur as a result of such incurable injury, disease, or illness whether or not life-sustaining procedures are utilized and the utilization of life-sustaining procedures would only artificially prolong the dying process.

Section 3. Requirements for Withholding Treatments; Concurrence of Second Physician

If any declarant shall execute a declaration, and, thereafter:

- (1) the declarant is diagnosed to have a terminal condition;
- (2) the declarant will die within a reasonably short period of time without the application of life-sustaining procedures;
- (3) the application of such life-sustaining procedures will only prolong the declarant's death;
- (4) the declarant is no longer capable of making medical decisions; and
- (5) the declarant has, or caused to have, the declaration made a part of his medical record;

Then the life-sustaining procedures may be withheld at the direction and under the supervision of the attending physician.

The determinations required hereinabove in this Section 3, paragraphs (1) through (4), shall be made by the attending physician and confirmed by a physician other than the attending physician, and upon such determination the declaration shall become operative as the final medical direction of a declarant.

Section 4. Physician Reliance on Declaration

The attending physician may rely upon a signed, witnessed, and dated declaration:

1. which expresses a desire of the declarant that no life-sustaining procedures be used to prolong dying if his condition is terminal; and
2. which states that the declarant is aware that the declaration authorizes a physician to withhold or withdraw life-sustaining procedures; and
3. which has been signed by the declarant in substantial conformity with the statutory law governing execution of Wills in this State.

Section 5. Form of Declaration

The declaration may be in a form similar in content and import to the following:

"DECLARATION OF A DESIRE FOR A NATURAL DEATH"

I, _____, willingly and voluntarily make known my desire that my dying be not prolonged under the circumstances set forth below, and do hereby declare:

If at any time I have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of which is not my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to prolong my death, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care and/or alleviation of pain.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed: _____

City, County, and State of Residence _____

The declarant is personally known to me and I believe (him/her) to be of sound mind.

Witness

Witness

Section 6. Revocation of Declaration

The declaration may be revoked by the declarant at any time prior to the determination that the declarant is no longer capable of making medical decisions, as provided in Section 3 of this Act, without regard to his physical or mental condition. Revocation shall be by any means by which the declarant evidences intent that a declaration is no longer to be effective.

Section 7. Declaration in Durable Power of Attorney

Declarant may, in a Durable Power of Attorney under the statutory laws of this State, designate some other person as his attorney-in-fact to make medical decisions on behalf of the declarant upon the determinations provided for in Section 4 of the Act, including the determination to withhold or terminate life-sustaining procedures. No act or decision by such Attorney-in-Fact made in good faith shall subject him to any civil or criminal liability, nor shall reliance on any decision or act by the Attorney-in-Fact subject any physician relying thereon in good faith to any civil or criminal liability.

Section 8. Effect of Declaration During Pregnancy

If a declarant has been diagnosed as pregnant, the declaration shall have no force or effect during the course of the declarant's pregnancy unless it is determined with a reasonable degree of medical certainty by the declarant's attending physician, and confirmed by another physician, that the prolongation of declarant's life by the continuation or application of life-sustaining procedures will not result in a live birth.

Section 9. Physician Immunity

After certification of a terminal condition, a physician who relies on a declaration executed under this act, of which he has no actual notice of revocation and who withholds life-sustaining procedures from the terminally-

ill patient who executed the declaration, is presumed to be acting in good faith. Unless it is alleged and proved that the physician's action violated the standard of reasonable professional care and judgment under the circumstances, he shall not be subject to civil or criminal liability.

Section 10. Physician Failure to Terminate Treatment

A failure by a physician to effectuate the declaration of a terminal patient shall constitute unprofessional conduct if the physician fails or refuses to make reasonable efforts to effect the transfer of the patient to another physician who will effectuate the declaration.

Section 11. Declaration not Suicide

The execution and consummation of declarations made in accordance with Section 4, 5, or 7 does not constitute suicide for any purpose.

Section 12. No Requirement Imposed to Make Declaration

No person is required to sign a declaration in accordance with Section 4, 5 or 7 as a condition for becoming insured under any insurance contract or for receiving any medical treatment.

Section 13. Mercy Killing Not Permitted

Nothing in this act may be construed to authorize or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

Section 14. No Presumption in Absence of Declaration

The absence of a declaration by an adult person not otherwise incompetent shall not give rise to any presumption as to his or her intent to consent or to refuse life-sustaining procedures.

Section 15. One Original; Safekeeping and Transfer; Construction

There shall be no more than one original of a declaration. It shall be the responsibility of a declarant to safekeep and transfer the document to his physician for inclusion in his medical records. No person shall be subject to civil or criminal liability for failure to disclose, transfer or safekeep such declaration, including an Attorney-in-Fact, it being the policy of this Act that a declarant may make such declaration, but no other person, even a volunteer, shall have imposed upon him any duty or obligation under this Act for which he may, by exercise of conscience, faith and/or beliefs held in good faith, later become liable for failure to exercise or carry out such obligation or duty.

Section 16. Consulting Physician's Immunity; Resumption of Treatment

a. The immunities provided to the attending physician under this Death with Dignity Act shall extend to any physician consulted by the attending physician.

b. Nothing in this Death with Dignity Act shall be construed to prohibit resumption of treatment of a declarant at the discretion of the attending physician as circumstances may warrant.

Section 17. Effective Date .

This act shall take effect upon approval by the Governor.

Presentation to the Joint Study Committee on Aging

October 1, 1986

Thomas E. Brown, Director
Office of Program Management
South Carolina Department of Health and Environmental Control

Representative Harris and Members of the Committee:

Thank you for the opportunity to address the study committee at this public hearing. My comments will be focused on two issues -- 1) the development a new data base for planning services and programs for elderly South Carolinians, and 2) the provision of in-home services for the frail, non-Medicaid elderly.

For a number of years, state policy development related to services for the elderly has focused on the Community Long Term Care project. From this effort, a Medicaid program of in-home services for the severely impaired elderly has been established. As we began to plan for health and social services for the elderly between now and the year 2,000, a number of questions and issues must be addressed. Examples of these questions are:

1. What are the current levels of health and disability among older South Carolinians and how will those levels change over the next 15 years?
2. What is the current and future relationship between health and disability status and the use of medical and social services?
3. What are the economic resources currently available to older people, and how will they change over time?
4. Will older people be willing and able to pay at least part of the cost of health and social services?
5. How do changes in economic resources lead to application and eligibility for publicly-funded health and social services programs?
6. To what extent are older people receiving assistance from informal sources such as family, friends, churches, and community organizations?
7. How will the availability of informal assistance change over the next 20 years?
8. Which factors encourage and discourage the use of formal services by older people?

To answer these questions, policymakers and program planners need a comprehensive profile of the entire elderly population in South Carolina which

includes demographic characteristics, functional health and disability characteristics, information on available economic resources, and information on current and future service needs. A study group composed of representatives from the major State agencies which either provide services or provide reimbursement for services to the elderly has been looking into the availability of data to address these questions. The investigation has examined the existing data on populations served by the Commission on Aging, DHEC, DSS and the Department of Mental Health, as well as national data on the elderly. There has been general agreement that these data are inadequate. Development of a longitudinal panel study is being considered. This methodology involves selection of a representative statewide sample of the state's elderly, successive surveys every three to four years, and development of a longitudinal data base. The method will provide data for policy development for the next 15-20 years, during which time the segment of our population over 65 years of age will become the largest single age group in South Carolina.

One concern with this approach is the cost of the survey. The estimate of the cost for the initial survey is \$400,000-\$500,000. The cost of future surveys will be less due to the high cost of drawing initial survey samples. When one considers, however, the large amount of money which is being expended and will be expended in the future on services to the elderly, I feel that development of this type of data is an absolute necessity. The Long Term Care Council is developing a detailed planning document related to this survey. It is scheduled for completion in November. I would like to encourage the committee's participation in this survey and to request your support securing funding to conduct this necessary and valuable policy planning activity.

The second issue which I would like to bring to the committee's attention is the need for in-home supportive services for the moderately impaired, non-Medicaid-eligible elderly. By moderately impaired I mean individuals who have an impairment in activities of daily living or instrumental activities of daily living but who are not so severely impaired as to qualify for skilled or intermediate level of care. Our existing service system for the moderately impaired elderly, who are not eligible for Community Long Term, is inhibited by inadequate resources and the lack of flexibility to allow individuals to participate in the cost of services. The majority of South Carolina's elderly have annual incomes between the Supplemental Security Income (SSI) level and \$15,000. Many of these individuals who are in need of in-home supportive services would be willing and capable of paying a portion of the cost of services through an organized, state subsidized service program. The size of this moderately impaired population is not known; however, I would estimate that it is 1-2 times as large as the approximately 5,000 individuals receiving services from the Community Long Term Care program each year. Incidentally, the size of this population could be estimated with great accuracy by the longitudinal survey discussed earlier.

Development of this new system would increase older people's choices about in-home services, facilitate their participation in the cost of services,

provide preventive services which will delay institutionalization and delay spend-down of resources and ultimate conversion to Medicaid. DHEC and the Commission of Aging have included funding for in-home supportive services for this population in their FY 87-88 budget request. The Commission on Aging has requested has an increase from the \$250,000 which has been provided through the Committee's assistance over the past two years. These requests are not duplicative nor would they serve individuals eligible for the Community Long Term Care program. Implementation of the in-home supportive services program could be coordinated well by DHEC and the Commission on Aging. I would like to recommend the Committee's support of these two requests.

Thank you again for the opportunity of discussing these two issues with the committee. I look forward to working with the committee during the next year to improve services which are available to elderly South Carolinians.

"The Slide to Anarchy"

Last year I was invited to speak at a public hearing before the Committee on Aging, October 2, 1985. I tried to talk but I was "neglected," ~~"BADGERED"~~ and "abused". Put it in your official record that the Committee on Aging abused a senior citizen, age - 69.

The talk I was not allowed to give is the same. America is "Sliding into Anarchy". Three phases of life was used to explain the situation. We have (1) unborn life, (2) newborn life, and (3) longborn life.

(1) Unborn life. This year we will have killed or murdered 20,000,000 unborn children. About 95% of the killing is due to convenience. It is all legal to kill for any or no reason. Listen to the abortionists in convention. "You have achieved a tremendous victory in the U.S. 1,500,000 abortions. This is in one year, 4,000 every day of the year. They would have you believe it is related to love. They are making a killing out of killing. This is big business about \$500,000,000 a year.

Read Frontenby report Dr. J. Kops about his three dominos, (1) abortion, clown (2) infanticide, falling (3) euthanasia, not standing

Read Dr. Christian Bernard showing the
relationships between the unborn & long born and
extraordinary.

Please don't tell me in life we have no
relationships from unborn to newborn to longborn.
We are sliding to Auschwitz. Don't tell me
that abortion would not lead to infanticide.

(2) Newborn life - we are now killing in the
hospitals. What do you think the doctor
does with a live baby after an abortion? Read
the Philadelphia Inquirer - Aug 2 - 1981

Dr. William Cates informs us we have about
"100 to 500 live births every year" He is the
expert who works with CDC and should have
Reporters will tell you for ^{years} that "becomes
known" a hundred probably go unreported.
Sold to Dr. Cates, show medicine handles
these cases. "It's like turning yourself in to
the IRS for an audit." "What is there to
to gain?" The tendency is not to report
because there are only negative reactions.

How about babies with an unfavorable QH?
A Down's Syndrome child quality of life is
low. A well known hospital put one off
in the corner. Babies don't die easily in
this case it took 15 days. What do you think
happens to the babies, eyes, mouth, tongue etc

in fifteen ^{days} (We are sliding to lunacy).

(3) Longman Life. The Hippocratic oath is not, Sanctity of life is not, quality of life is in killing the unborn, and abortion is a fancy of euthanasia. Governor Lamm exposes the mentality of the age - "You have a duty to die". South Carolina has its living will, the Uniform Law Committee says - Yes - South Carolina wants a Uniform Living Will Law. The illustration for this living will bill.

(1) The Committee wants to know why do we have to put in the law - There is not a euthanasia bill. You want it to pass, don't you. This is funny. Ha! Ha! We are playing with life or death.

(2) Does the Uniform Law permit starvation. No, if you don't want to starve to death, you write in your will what you desire to starve ^{not} to starve. We must do better, than this. The next change.

History is the only one in the history of the world to give us euthanasia by deliberate intent. Will America "Slide to lunacy". Under no change in thinking, feeling and action, we will stumble into lunacy. Then we will say, "I didn't mean it would come to this". Remember, from the start, it all started when we started killing for convenience (the end).

John Hallenbaugh

John Hallenbaugh
2-4-12